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ORIGINAL

TRANSCRIPT OF PROCEEDINGS

DEPARTMENT OF HEALTH EDUCATION AND WELFARE

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DIVISION OF REGIONAL MEDICAL PROGRAMS

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AD HOC REVIEW COMMITTEE

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PANAL A

Rockville, Maryland
May 23, 1974

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C O N T E N T S

DEPARTMENT OF HEALTH, EDUCATION AND

WELFARE

AD HOC CONSULTANTS MEETING FOR REVIEW OF

RMP APPLICATIONS

Conference Room H
Parklawn Building
5600 Fishers Lane
Rockville, Maryland

8:30 A.M.
Thursday
May 23, 1974

5/23 am
D/em
8:40 am

PROCEEDINGS

MR. CHAMBLISS: I would like to say, first of all, good morning to the members of this panel. I indeed commend you again for the diligence and the zeal that you tackled this most difficult task we had yesterday.

I would like also to welcome to the panel Dr. Scherlis. Good morning, Dr. Scherlis.

DR. SCHERLIS: The expression is "the late Dr. Scherlis".

MR. CHAMBLISS: And say we are glad to see you, and we are still waiting on Mrs. Wyckoff and Dr. Miller; but, if the committee so chooses, I think we can proceed.

We're halfway through with our task and today we have fourteen regions yet to be reviewed. The order that I would suggest, and certainly this can be changed, would be along the following lines: Iowa, Memphis, Missouri, Nebraska, New Mexico, North Carolina, North Dakota, Northlands, Ohio Valley, Oklahoma, South Carolina, South Dakota, Tennessee and Mid South, and finally Texas.

DR. SLATER: Sir, I have to catch a 5:10 train at the Capital Beltway, so I have to leave here about 4:15 or maybe a little later, if it's not raining; and I'm on Texas. I can tell you Texas won't take more than five minutes. Jesse Salazar is the primary reviewer, it will take ten minutes.

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MR. CHAMBLISS: It will take ten minutes.

DR. SLATER: We should be able to finish.

MR. CHAMBLIS: I could make the suggestion that we take Texas now. It's too hot in Texas to start with Texas.

DR. SLATER: We're anxious to talk with each other, because this requires some preliminary review by us to be able to make a sensible presentation. So if you could do it after lunch, we'd appreciate it.

MR. CHAMBLISS: After lunch? All right, we will start out with Texas immediately after the lunch hour.

DR. WHITE: Bob, where do we stand in terms of relationship with the other panel?

MR. CHAMBLIS: The other panel, as of last night, had completed nine out of 23, and we had completed 14 out of 28.

DR. WHITE: Some of us have suggested a target of this afternoon's joint meeting. Is there some way they can be reinforced in their efforts?

MR. VAN WINKLE: We talked with Dr. Pahl just a minute ago and he's over reinforcing that right now.

MR. CHAMBLISS: A suggestion has been made that the first panel that completes its work would go over and join the other and help them speed up.

DR. CARPENTER: I also have to leave about four, and Northlands is therefore a bit of a problem, maybe, except

if we finish on schedule it won't be.

MR. CHAMBLISS: I think we'll get to Northlands about near the lunch hour, just before or just after.

DR. CARPENTER: Thank you, sir.

MR. CHAMBLIS: Then, shall we begin with Iowa, and welcome Mrs. Wyckoff.

MRS. WYCKOFF: Sorry to be late; I couldn't get a cab.

REGIONAL MEDICAL PROGRAM REVIEW

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MR. CHAMBLISS: In the case of Iowa, Dr. McPhedran and Mrs. Salazar are the reviewers and Mr. Zivlavsky is the staff support, will provide staff support.

DR. McPHEDRAN: I am recommending that we give Iowa the amount that they are asking for. I think this is a good Regional Medical Program.

And to go through the categories that were suggested on the review sheet, first of all, a little background from me: I site visited Iowa in the past, it was several years ago, but a lot of the direction of the program that was there at the time is still there, and I've had occasion to meet with Charles Caldwell on one or two times since then, and he continues to impress me as an imaginative coordinator.

From what is presented in the application, it sounds as though the Regional Advisory Group, for example, had great stength then and continues to be a strength, anticipating the form of the review sheet.

To return to that, the program leadership I classify as at least satisfactory, and the staff as generally good in the Regional Advisory Group; a good group there. The kinds of meetings they have held in the past to develop programs and to monitor it as it goes along, seemed imaginative and very much to the point.

Past performance and accomplishments as satisfactory also. Satisfactory in all of the other categories.

I guess that the program staff and the Regional Advisory Group principally were the factors that make me feel that the over-all assessment of the region is above average. It is a well-administered staff of generalists. It's a stated policy, that is, that persons on the staff retain some general competency in various activities that they conduct.

There's a good deal of emphasis on joint decision making on the staff members. This is gone over in the current application.

I think that they have, as I say, a good Regional Advisory Group support.

The only sour note, I guess, for me, was that the relationships with Comprehensive Health Planning, which I thought previously were quite good, seemed to be somewhat less than satisfactory, as judged from some letters that I think are included in our notebook here, which were not in the original application.

But, on the whole, I think that the general program purposes and their past accomplishments simply weren't what they have been asking for. And, according to this master financial sheet, which perhaps I found more helpful than I should, what they are asking for constitutes only 80 percent

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of what it was thought they could have in targeted available funds.

And even if they are expecting to request in July, it would only come to about 95 percent.

I really think with the management and direction of this program, it has been good enough in the past that it certainly warrants that kind of support, without going into further detail.

MR. CHAMBLISS: Thank you, Dr. McPhedran.

Mrs. Salazar.

MRS. SALAZAR: I subscribe to Dr. McPhedran's views, and this is the impression that I gleaned from the application.

However, there are some concerns which I had an occasion to discuss with Frank briefly about the CHP involvement and some other comments. But the timing seemed to be bad, that they just couldn't get to them. I would like to hear from Frank.

MR. CHAMBLISS: Mr. Zivlavsky, would you --

MR. ZIVLAVSKY: Iowa, from the beginning, had a very close working relationship with CHP. They have maintained that relationship throughout their program history.

What they have in the application is actually one non-official B Agency comment, that there are 15 CHP agencies in the State, five of the 15 are actually approved B agencies.

The comment you have here is a comment from one of the non-CHP B agencies. They telephoned them in to Division RMP and requested a three-day delay in their application. This was approved, and they submitted it on the 3rd of May instead of May 1st.

They just admit it's a breakdown in their machinery for the CHP to be processed, because they have always taken into account the CHP comments, have been able to negotiate their differences with CHP. They have submitted five additional letters here, but basically two CHP agencies have delayed their review. One has favorable comments. One has a recommendation for disapproval. And the last line, I just state that the Iowa CHP has not yet responded to negative comments or questions due to the short timeframe.

We received these on the 20th of May, and inserted these into the books of the reviewers and the coordinator, and we have not had an official chance to sit down and negotiate on a one-to-one basis with each of the differences of the CHP agencies. And I,usually they have a comment in there that it's a breakdown in their machinery. The staff is on top of it.

I will be watching this closely, and that's really about where it is.

MRS. SALAZAR: One of the things that I noted in reading the application is the resiliency of this staff to

react and turn around and react to all kinds of crises, in a very flexible manner. And I think that's very good.

MR. CHAMBLISS: Someone has said that's based on their youth, because they all are very go-go types, young, aggressive, they move quite fast. I simply throw that in as an observation.

DR. McPHEDRAN: So I would move that they be funded in the amount requested, which, to reiterate, is $1,061,349.

MR. CHAMBLIS: We have a motion on the floor that Iowa be funded, recommended for funding at a level of $1,061,349. Is that seconded?

DR. MILLER: Well, the yellow sheet says 249; but maybe there's a mistake here.

DR. WHITE: What is Mr. Caldwell's background?

MR. CHAMBLISS: I believe his background is either in hospital administration or public administration.

DR. WHITE: He's about the third coordinator they have had, isn't he?

MR. CHAMBLISS: To my knowledge he is the second.

DR. McPHEDRAN: Second.

DR. WHITE: Willard Prell was first.

MR. VAN WINKLE: That is 249.

DR. McPHEDRAN: Okay. Amend that.

MR. CHAMBLISS: Do you amend the motion?

Is there a second to the motion?

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MRS. SALAZAR: I second it.

MR. PULLEN: It adds up to 349.

MR. CHAMBLISS: It has been properly moved and seconded that Iowa be recommended for the level of $1,061,349.

It has been seconded, so we now may have discussion.

DR. SCHERLIS: I note that one of the projects is for emergency medical systems. I thought that was specifically exempted unless there were continuing projects. Is this a continuing project? It's for $74,500.

MR. CHAMBLISS: It is a continuing project.

DR. McPHEDRAN: Yes, I think it is a continuing project.

MR. CHAMBLISS: Continuation of a previously funded project.

Is there further discussion?

If not, the Chair calls the question.

Those in favor?

[Chorus of "ayes".]

MR. CHAMBLISS: Those opposed?

[No response.]

MR. CHAMBLISS: The "ayes" have it, and the motion passes.

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REGIONAL MEDICAL PROGRAM REVIEW

MEMPHIS

MR. CHAMBLISS: So we will now turn our attention to the Memphis Regional Medical Program.

The reviews there are Dr. Carpenter and Mrs. Wyckoff, with Mrs. Lorraine Kyttle providing staff support.

DR. CARPENTER: This is a region that I've had an opportunity to visit. As many of you may know, it is an interesting Regional Medical Program involving part of five States and growing out of an existing health planning body in the Memphis area. That body later became a Comprehensive Health Planning agency for the area, and that growth of the regional program made a great series of State and local RMP's, naturally, and probably it would have been an impossible situation without that beginning.

But it really has worked well, and given the Memphis Regional Program, I think, a particular characteristic of its own.

In some ways it seems to me to behave like a very broad planning agency. The nature of the Comprehensive Health Planning agency, as much as it behaves like a Regional Health Program. But I don't think it's all bad.

This is a data analysis that attempts to get into health care problems in the region. It is the latest in a series of publications based on data that was, demographic

data that was available and re-analyzed to meet the region's needs. Also surveys of health in various places in the region.

As usual, in the world, it's very difficult to determine that the program has been guided in direct ways by this kind of data analysis, but I believe the ability of the region to generate that kind of data and to reinforce and talk about the health care needs of Memphis has provided them with a kind of credibility leverage that has been important in the development of the program.

The region has a relatively stable staff. The coordinator has been there, Culbertson, for a long time. And they have a stable -- well, they have had some changes in their varying structure because we had legal questions about the original arrangements. They are now settled down into a standard RAG arrangement, and that was not terribly adversely affected by the regional catastrophes.

They are not terribly explicit in the way they write their application. They list, I guess, four goals and 13 objectives; and, as I tried to analyze them, I come up with what I really think are seven ideas. And these are related nicely to the usual medical goals of the Regional Program, and I don't see any problem there.

They discuss priorities as though they were separate from their goals and objectives, which is a little discon-

certing, but by the time one o'clock came around I had solved the fact that they were really paraphrases, and one can in fact group their goals and objectives into some range of priorities.

The request is for about $700,000 in core support, a million six for 28 continuing applications and a million for nine new applications; $300,000 for developmental awards.

The projects from the beginning of this region have not had very specific goals. They have been very general: Let's get together, sometimes plan; let's get together for general action kinds of goals. And they've not been evaluated particularly well.

I have great difficulty in this application in understanding in some ways what they have accomplished.

On the other hand, they have brought in an enormous number of dollars from other sources to the region, or at least have contributed to it, and because of this very close working relationship between Comprehensive Health Planning, experimental health care delivery systems, and Regional Medical Programs in the area, it is very difficult to give credit for what happens. Which is certainly not a complaint at all, but it does make evaluation very difficult.

I believe that the Regional Program in that area had a significant role in bringing something like a half million dollars to the region in other support in each of the

last three years.

They estimate that they have served 200,000 patients in the last year, and about 2,000 professionals have been trained. So there are some kinds of program evaluation that are available; but, again, the project evaluation is a problem. And one almost gets the feeling that the projects were ancillary to the main issue.

Which, again, I think is more an interesting different approach, perhaps; but there are some difficulties, I think.

There is, for instance, $60,000 invested in a project to improve death certificates. Which really turns out to be an experiment by one of the pathologists who does one and a half autopsies a week, and tries to see whether X-rays and gastric analysis would add anything to his ability to perform as a pathologist.

That was hard for me to see as a Regional Program.

MR. THOMPSON: It's interesting, though.

DR. CARPENTER: It's very interesting.

Of the million dollars, roughly, for the nine new projects, half of it goes for area education centers in ten hospitals, and really, this project, half a million dollar project buys an organizer, a librarian, and provides space rental to the hospital, provides a secretary and some books, journals, and audio-visual material for the area.

And the outputs of that project are said to be to list the educational and clinical resources in the area of these ten hospitals, to relate the leadership of the clinical and educational resources to determine the need for new educational programs, and to develop an over-all manpower plan.

Now, I just believe that that's the work of the Advisory Committees, not $500,000 worth of staff. And I also -- I don't know, at a time when this program is going to be phasing out, I wonder what the meaning of a developmental award is.

Now, let me stop at that point and see what my cohort would say.

MRS. WYCKOFF: Well, I think Memphis has the most beautiful case of euphora about RMP than any of the RMP's. They have chronic optimism about how this thing is going to go on, and they are just going to conquer all the problems in the world. And it's partly due to Dr. Culbertson's personality. He carries the thing on his back pretty well.

They also operate as a very peculiar animal. They are different from any other RMP, because they're like a family. They seem to telephone each other and keep in touch with each other across State lines and across all the terrible amount of paperwork and rules and regulations that

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exist. They rise above it all and do it in an informal fashion, and they seem to get together after hours and keep the wheels very well oiled, and do the things that have to be done.

It's an incredible thing, and they cannot believe that they are going to be phased out. They just don't believe it.

Instead, as you can see from this report, they make all kinds of alternative plans, so they're going to survive no matter what.

And I really have a little faith in them. I honestly think they may be able to do it. They have put it together, they have got this experimental health systems management agency, and of course their Comprehensive Health Planning Groups, and the RMP, and they are planning to get ready to jump in any direction when the legislation comes through. They are going to be ready for anything. So I think their development funds will be used to launch whatever needs to be launched at that time.

They show more faith in survival, when the crunch went on, they went right ahead with their plans, and they are all ready to get their maximum amount of money with new projects and everything when the funds came through.

They have only seven -- I think it was out of, was it 18? They had only seven approved and unfunded requests

at the end, and I think they had 11 that way, succeeded in putting through at the worst possible moment.

So I really think that they may be able to make a go of this.

I would like to hear a little from staff on what they know about the new plans they have for this new trusteeship board. If there is anything in there.

DR. WHITE: I wonder if Mrs. Kyttle might also comment on this phrase "escrow accounts". Is that a substitute for keeping money after the thing is over?

DR. CARPENTER: That's a catalysm.

MRS. KYTTLE: Well, you asked about the organization that is forming, and you are quite right. It's almost incestuous, because NMCC's spawned RMP, and RMP's spawned HSM. RMP responded to the RFP that R&D issued for experimental health systems, wrote the application, pulled the people together, set it under a corporative kind of stance, because that's what the RFP requires, and Voila, there's Health Systems Management, Inc., which is right across the hall from RMP.

DR. McPHEDRAN: I'm on the ropes, Mrs. Kyttle. RFP, R&D sent out a request for contract proposals across the country. That's a request for contract proposals, for proposals on experimental health delivery systems. Regional Medical Programs in Memphis sat down and wrote one, but did

not send it in under their name, because they were not at that time a proper applicant. They spawned HSM, RMP and the local B, which is one of the most active B's in the State of Tennessee, not just west Tennessee but in the State of Tennessee, had formed an umbrella trusteeship -- and that's not a catalysm; that's theirs. They call it an umbrella trusteeship.

It proposes the merger of the executive committee of each of these agencies, and it is a straight-forward, unabashed move to present the three of them. This is not an area where one is more interested in surving over the other.

The three of them want to survive.

They did an interesting thing. They agreed that each of these three entities, if their full boards ratified it, and since this paper was prepared all of the boards have ratified it, the full boards. The body bringing the largest turf to this umbrella trusteeship, and without doubt that's RMP with parts of five States, would bring the turf or cognizance of this new group, should the turf want that.

And so there is, then, the possibility that there would be an 80-county five-State Health Service Agency or whatever might come out of the new legislation.

They thought that that would be the experiment, and that's the purpose of that organization you asked about.

MRS. WYCKOFF: They believe in survival.

MRS. KYTTLE: The three of them, not just RMP.

MR. THOMPSON: It does offer complications, however. We're used to, you know, the one-on-one business, who's on, who's off, between CHP and RMP.

Now, they have substituted a menage a trois kind of thing, to complicate it even more.

MRS. KYTTLE: I don't know if they look at it as a complication in that frame. The possible complication is that Memphis RMP has assisted, and that is from beginning to where they are now, all other B's in west Tennessee, all of them. But the one that is operating in southeast Kentucky is a Memphis RMP, funded not any longer, but it was.

MRS. WYCKOFF: And Mississippi.

MRS. KYTTLE: Northern Mississippi and the boot-heel of Missouri and eastern Arkansas. The five operating B's are all B's that have been funded and initiated by Memphis RMP.

Now, if Memphis RMP comes into this umbrella trusteeship with the greatest territory, it will encompass the territory of those B's, and they know that, and they realize that that will be the option. If those local B's and indeed the legislation permits that type of arrangement, they thought that that would be the interesting experiment to form a new Health Service Agency for that terrain, wit- subcontracts with existing B's, that they have already funded.

MRS. WYCKOFF: I guess you have to give Dr. Cannon a little credit for also holding this organization together.

MRS. KYTTLE: Yes, ma'am.

DR. SCHERLIS: How much of the funding actually would be directed toward the setting up of such a group? How much of it is seed money?

MRS. KYTTLE: They seek no funds for that. The arrangement they have made is that they are rotating for the first period of operation, the executive director of HMS serves as the chairman of this new board. The staff is provided by RMP, and the leg work is done by CHP.

And for the next ninety days, they first started thinking of a year and they realized that that would be too long a time, the next ninety days the coordinator of RMP serves as chairman; the staff of HSM has to fund the money to get the staff work done, and the CHP organization does the regional communicating.

DR. SCHERLIS: You told us about that $400,000 in escrow.

DR. WHITE: There's actually 800,000. There are actually two different escrow accounts.

MRS. KYTTLE: This application seeks no money for that organization.

DR. SCHERLIS: Yes. But where does the money come

from?

Two things: how is it labeled, and how can a sum of money be available?

MRS. KYTTLE: All right, that's the first question you asked about. The $800,000, when you total the two, it's a combination of five and three. Let's speak to the 500 first, and that is the creation of local consortia to develop health manpower needs and relate them to identified health service needs, and relate them to health manpower resources.

MR. CHAMBLISS: Is that to which the funds are going to be used?

MRS. KYTTLE: Five hundred thousand.

DR. CARPENTER: That's for ten hospital librarians, ten secretaries, and ten planners, community organizers.

MRS. KYTTLE: You asked if that should not be the work of the local advisory committee, because so many of these groups were formed from such advisory committees; but they have no local advisory committees. These are predominantly in ares where there are not B's, and this is how Memphis starts B's.

DR. CARPENTER: No, they have B agencies now except in -- organized in every area, but not --

MRS. KYTTLE: They are not funded.

DR. CARPENTER: Two of them are not funded. But they are two out of ten at most.

No, these are not B agencies, these are --

MRS. WYCKOFF: Health Centers.

DR. CARPENTER: These are hospital libraries.

MRS. WYCKOFF: There's the seed money to start things.

MRS. KYTTLE: I said they have no local advisory committee in these areas, save Jackson. There is one in Jackson, and there's one ongoing there.

DR. CARPENTER: But they showed us a map of the B agencies, right, and they cover the whole area except maybe a few outlying counties.

MRS. KYTTLE: These are areas that have no health manpower committees working in them.

DR. CARPENTER: Oh, okay. No manpower committees.

MRS. KYTTLE: And that's how they have spawned, they have first developed some health manpower committees for B's. These are areas where the B's have formed without health manpower committees.

DR. CARPENTER: That's the point I'm making. If they had the manpower committees, they wouldn't have to spend a half a million dollars.

MRS. KYTTLE: Well, for some reason, and I have tried to research it and I don't understand it, the philosophy,

the Memphis Regional Program thinks local consortia to address health manpower needs should be seated in a hospital. They feel the hospital setting is the setting for an HSEA, and they have felt that way from the very beginning. And that's where these are, ten sites.

MR. CHAMBLISS: Dr. Scherlis.

DR. SCHERLIS: Now we've gotten through the first gear, what happens to the second ten libraries, secretaries, et cetera, for the second year? They are being funded?

MRS. KYTTLE: The same thing that will happen for all the others. Some of them will make application under the new legislation as health service agencies. I mean, that's going to happen across the country. Most of them feel that they are ready to make application.

MR. THOMPSON: Ten libraries are going to be certified as health agencies, as I understand you?

MRS. KYTTLE: One of the first things the local area is going to have to do is to create its own manpower committee. The librarian will not be -- even she's a part of the system, but she is not the pivot.

DR. WHITE: I'm suffering from an inability to recall Webster's definition of "escrow". But it seems to me it has to do with putting money aside for future use.

MRS. KYTTLE: They want to impound their own money. They want to put $500,000 aside now so that they feel

by July they will have gotten these things ready to go to contracts, or in the writing stage now of when, I think one is in Kentucky and the other is in Crittenden County in Arkansas. Rather than coming in in July with this proposal of ten sites all worked up, they want to escrow the money out of the total package now, so that it can begin in July rather than make application to us in July.

MR. THOMPSON: So, in other words, they want to use the escrow business as a substitute for a specific proposal.

MRS. KYTTLE: Yes, and they want to tell you now what they want to put it aside for.

MR. THOMPSON: Has this proposal been matched up through the whole internal review process as a proposal?

MRS. KYTTLE: As a concept.

DR. CARPENTER: I think there are a series of small proposals. Isn't that the way it got through the RAG as small proposals? But it did in part, in $25,000 hunks it went through RAG.

MR. THOMPSON: $25,000 hunks up to $500,000? That's a nice piece of business.

DR. WHITE: They have got $800,000 there.

MRS. KYTTLE: And it all went through at once.

DR. CARPENTER: They didn't hide any of it.

MRS. KYTTLE: It did not bleed through, it went through as a concept, and $25,000 apiece for ten sites.

DR. CARPENTER: Can I, at this point, break into the conversation and make a funding recommendation?

MR. CHAMBLISS: You may, indeed, Dr. Carpenter.

DR. CARPENTER: I would, just to get the discussion going, move a certain funding level. Their annualized rate now is a million and a half. Their targeted rate is about two million three, and they request three million four now and predict that they will ask for a million two later, and that will get them at two times target.

I think that the region is pretty good, but not in a position to go from a million and a half to four million seven at the time of phase-down. I would suggest a funding level a little above the target level, of $2,600,000.

MR. CHAMBLISS: Will you place that in the form of a motion?

DR. CARPENTER: Yes, I do.

MRS. WYCKOFF: I'll second that.

MR. CHAMBLISS: It has been moved and seconded that the level be established for -- be recommended for Memphis at $2,600,000.

Is there discussion?

DR. WHITE: I would like to pursue this further, and I am going to. We've talked about the 500,000. There's another 300,000 in escrow dollars, which I interpret as this, Mrs. Kyttle, as underwriting the survival of these three in

whatever form they're going to take.

It says that, I think.

MRS. KYTTLE: It says that high priority out of this developmental will be given to those agencies, you know, in the total region. That's the RMP region that I'm pursuing, the logical kinds of things that the new legislation proposes.

There again that falls within the umbrella purview, but the umbrella -- the organization that is the umbrella is not seeking funds, but it seeks to fortify its philosophy that it's a good umbrella, it hopes that the legislation will speak to a State, you know, whichever one comes out first, and it wants to have agencies funded within it, that it can contract with.

That's what the high priority is for those agencies.

DR. WHITE: Now, is that $300,000 the same as the developmental fund?

MRS. KYTTLE: Some of those are B's. Yes, that's out of that.

MR. THOMPSON: I think what we see here is probably the bald statement of the problem that you are finding more or less in the same degree in all of these, most of the proposals, and this is an attempt to second-guess what the legislation is going to be as far as, you know, whether this is regional health authority or State health authority,

and it's floating around in all these crazy bills.

Now, I think we have a policy problem here, whether our RMP funds should be used to relate an agency, a proposed agency for nonexistent legislation. And I think that's true here, I think that's true in a subsequent thing that I'll review to you.

In other words, when you, from RMPS sent the message down: Fellows, get on the ball with your CHP and no kidding this time. We've seen a lot of getting into bed with CHP, and it's -- in fact it now looks like a plot by the two of them to survive, whatever happens.

Now, I don't know what's going to happen if this legislation setting up this envisioned Regional Health Authority is delayed by two years. You know, all this money that we're pouring in here to build these various elaborate umbrella agencies, the consortia -- they have about six names for it -- it's going right down the old tube.

MR. VAN WINKLE: I would like to point out that they have been encouraged to start various programs with CHP.

MR. THOMPSON: That's what I'd like to know: who has the crystal-ball authority that they can tell me that the Regional Health Authority is going to be established by the end of RMP's life, and take over RMP's staff or skills, and start in business. Who the hell has got that information? I don't have it.

MRS. KYTTLE: Mr. Thompson, you know it would be beautiful if that were the case, but no region has had that word, and they are all trying to take the most logical and flexible stance that they can, trying to provide for the possibility of State structure as well as providing for the local structures, until they see what the legislation is.

MR. THOMPSON: When you cover all the bets on a racehorse it costs a lot of money, and that's what these people are doing. They're putting two bucks on every horse in the race, hoping that somebody will come in and they will be on it! As long as it's not their money, that's okay.

MR. CHAMBLISS: This is one of the policy questions that we alluded to earlier on when the committee was convened, and this is one of the issues that will be dealt with as the review goes forward.

I would like to acknowledge the presence of Dr. Margolis here, our former Director. And since this is a policy issue, I'm wondering if he would say a few words on this point.

DR. SCHERLIS: I was just going to make one suggestion. I think that Memphis really shows some good judgment with the idea of an escrow account for $800,000 and I would think that some of the wisest judgment that this Review Committee could make is to have an escrow account of a hundred, a hundred and twenty to forty thousand dollars

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that we would have available, and say, let's save that for some decent health planning as of July 1st, 1975.

While I wasn't here yesterday, which is a calendar error that I apologize for, I spent, really, as all of you did, a very difficult time reviewing these, because we're doing it on promise and hope and faith and, frankly, charity.

And all the old judgments that we have used have had to go down the drain completely in reviewing these; and I think that if Memphis gets approved for an escrow account, that my next suggestion will be that we vote an escrow account of a hundred or eighty million dollars for July 1st, to be used if there will be health planning then.

I don't think that putting this into some thirty, forty, fifty little different projects, that we're begged for and scrounged for by going out and saying, Come on in, we have this last chance to get it. A lot of them read that way. That that is really the equitable way for us to use government funds.

I have the serious questions that all of you have had, and we're operating within a very difficult framework, to reach equitable decisions.

I am all for escrow accounts, particularly of most of that one hundred and twenty or hundred and forty million dollars.

I didn't mean to pre-empt you, but I wanted that stated somewhere along the line.

DR. MARGOLIS: Well, my most positive word is that I am delighted to see my good friends here again. I am delighted to see that you are tearing at things as usual.

I don't understand your concern, John, in not knowing how to spend money on nonexistent legislation. After all, money was appropriated, impounded in '73 to be spent in '76; when the authorization would expire by June 30th, anyway.

So it's a perfectly clearcut situation!

I would like to address this question, because I think the points you raise are important, and rather than matters of policy, although they certainly involve policy, there are also senses of timing in judgment, which will have to replace, as they often have in this program, some kind of policy base. In all of the discussions on planning, legislation, developed both some kind of unified health planning proposal, there has been more dissatisfaction -- and not very well hidden -- than satisfaction with everybody's proposal, as you implied.

The administration is not wildly enthusiastic about what it has proposed. The Rogers Committee feels about the same about its own proposals. There is great uneasiness

about what would occur. Time is running out. And some of the basic problems remain.

The problem which everyone has looked at, usually defined so poorly, that it is looked at plainly, is the meaning of planning, the relationship between planning and implementation; and the relationships between planning and management.

Traditional questions which have been up for consideration time and time again. The difficulty involved in all the pieces of legislation and in the debates which really don't get around to this is that no one is ready to say what that relationship ought to be. Nobody is willing to come down hard, although there are indications that a position has been developed.

For example, it is now felt that whatever these health service agencies will be, or whatever name they come out under, they will be private, nonprofit structures within the State. There will be an uncertain kind of support for State structures. The planning process will be kept from State implementation, however, there will be some small amount of money for implementation, a larger amount of money for implementation based on whose bill you're looking at.

What is missing in the process is something which can produce, in the health delivery system, a cooperative

structure which allows people to operate in the private and in the nonprivate systems in such a way that they are able to do together more effectively those things which they wish to do than they can do them separately. Which is an early description of Regional Medical Programs.

It creates a real problem. And in many ways what our reviews are attempting to do is being approached under other names, with different kinds of understanding, and with a variety of methods.

But the debate has not been joined. I don't think it will be joined. And when you're through with this session and we're through with the review session which is coming up after that, there is still going to be great difficulty in making a judgment about what is RMP going to do in relationship to CHP, what will the planning function actually be, what will the relationships be between planning and implementation; and, furthermore, what is going to be the role of the State government in this?

Because, in general, the role of State goverment has been downgraded,almost lost sight of, there have been serious objections to it from outside and from within. And we're going to be entering the fall season whether using an escrow account or not, with no more certainty about what that relationship is than exists at the present time.

What we have been saying is a consequence, and it's

about the only way out, maybe not too bad a one, is that the most proved factor beyond a Regional Medical Program, and it's now my job in addressing all these programs, it applies to others as well, certainly the CHP; but beyond the CHP, the other kinds of federal programs which are in the States which have sort of opted out of this activity, the most judicious thing for them to do is to get together with one another as rapidly and as fully and as enthusiastically as possible, and decide what they're going to do together, regardless of what the legislation is going to look like.

And between the passage or nonpassage, which is a good likelihood, of the legislation, its approval, its appropriation, its regulations and its administration, so many things will occur that if the people who are out there quit trying to decide who is going to be in charge and decide how they are going to run the thing together, they are going to move rapidly ahead.

Now, sometimes this is interpretative on the part of RMP people, if I'm talking to them, as some of the RMP's are, is that they should quickly move to take over.

Now, that wouldn't work. CHP takes the same response when they are listening to their own partisans; it's for you to take over.

And if they will get just a little smarter, they will move together; but they are going to have to move with

other programs. Maternal and Child Health Service, Community Mental Health Service, which, for some reason, along with others, have never been considered a part of the general concept of comprehensive planning.

Migrant programs, all of them have each been looked at separately, and all the conversations have been RFP and CHP as if those were the only actors in the game; when, in fact, they are some of the actors, and in many instances rather minor actors.

Now, I think the additional thing which is going to make a difference, about the time we get started with it, is the growing concern with the regulatory function within the State which will produce an entirely different environment for the total relationship between planning and implementation. Because the regulatory function will throw in a new responsibility which must be a State responsibility, almost by definition.

That regulatory function already applies to institutional development. It's going to, in all likelihood, involve cost control, because we get national health insurance, and there is freer and freer conversation now about a complement to certificate-of-need legislation for construction, and that will be some kind of certificate-of-need for manpower.

Now, when these kinds of things occur, people who

have been vying for responsibility may find themselves vying for getting out of sight; because it's going to be no child's game.

And yet by looking at the total structure, as it will be much faster than many of us have expected, the relationships between the planning, the implementation, the operational and the regulatory functions can become clearer, and the responsibilities for the various parts will begin to fall into place.

But to try to assume full management or full authority for any one of them is injudicious, it won't work, and I don't think anyone would really want it when they get all through with it.

The real struggle, in all sincerity, will be on the part of those who are determined that the regulatory function, particularly control of rates and fees, be placed anywhere but where I am. Nobody is going to want that. And yet it is going to be the part of the system which is going to have the greatest power, and from which most of the strength is going to flow within the States.

I think it will go in the States gradually. The other big debate is whether the National Health Insurance is to be more federal or State directed; but that's a very fundamental issue.

Now, I know that's not a policy thing, but at least

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it's a statement of some kind of dynamics which will work well some places and not others. The concept of escrow, I would certainly agree with you, is certainly -- if you're going to consider the setting aside of funds for an uncertain but realizable goal in the immediate future, that should be a programmatic kind of action across the board, rather than limited to any one program, to come up with that kind of an idea

And even then, it is a risky kind of thing to do, because you don't know what the situation will be when those funds are released.

I don't know if that helps or not.

MR. CHAMBLISS: Well, thank you, Dr. Margolis. There may be some questions that the panel would like to raise, in addition to -- Dr. Vaun?

DR. VAUN: Getting back to this, not with regard to Dr. Margolis' comments, the only thing that concerns me about the escrow is that, does this place any of the other RMP's that have seen fit to come back in July, at a disadvantage?

In other words, are these people gambling that all money is going to be doled out on the first round, and, really, what you've been saying is not so there won't be any money left for the second round, so they're putting their little nest-egg in escrow.

Has that thought occurred to anybody? Is this what they are trying to do?

MR. CHAMBLISS: There will be a sum of moneys remaining for the second round.

DR. VAUN: So as you envisage it, this would be not placing anybody at a disadvantage? The other RMP's.

MR. CHAMBLISS: Well, the total amount is limited, so therefore what is ultimately awarded to Memphis comes out of the entire amount available.

DR. MILLER: Isn't it true that previously, except for developmental fund awards, which has not been mentioned in the current directions, no region was allowed to just apply for escrow funds, by lump of escrow money. You got it another way. But you couldn't apply for escrow funds.

And now you do not have an authorization or direction for regions to apply for a development award, either; do you?

MR. CHAMBLISS: We do not.

DR.MILLER: Well, isn't it appropriate that this review committee specifically record in the record that we do not recommend funding for that activity or that kind of an award, that part?

MR. CHAMBLISS: That would be a problem, and we are looking to this committee for its judgment on that.

DR. MILLER: Do you want that in the form of a motion?

MR. CHAMBLISS: A motion is not in order at the present time. There is a motion on the floor, and that motion is that the level of funding for Memphis be recommended at $2,684,000.

MRS. WYCKOFF: Well, why don't we do it?

MR. CHAMBLISS: You may so indicate that, and the staff people will take due notice of it.

MRS. WYCKOFF: Should we amend the motion that the escrow funds be taken out of this?

DR. WHITE: All of the escrow funds are on the yellow sheet, they are not on the application. The awards. What you see on the application is a developmental award and a project, and I believe we are not supposed to get so deeply into the region's management as to reject a specific project.

I guess I have the feeling that if we reduce the requested funds by an appropriate amount, the region will probably behave fairly well. And I would be satisfied just to reduce the funding amount and then proceed.

Does that make sense to anybody?

DR. McPHEDRAN: Then how about, as a separate piece of business that does not have anything to do with this particular consideration of this program, that we could have this motion that Dr. Miller suggests. Could we do that?

Just as a general part of the proceedings of this committee. If we could do it that way.

MR. VAN WINKLE: But the staff can also express your concern about these two items.

MR. CHAMBLISS: Then I call the question.

Those in favor please indicate by the usual sign in voting.

[Chorus of "ayes".]

MR. CHAMBLISS: Those opposed?

[No response.]

MR. CHAMBLIS: The motion is carried. At two million six, with the concerns of this panel being conveyed to the region in the advice letter and by staff.

I must say that the privilege that we've had of having Dr. Margolis, the Deputy Administrator of the Health Resources Administration, come in just at this key moment, when we were discussing a very critical issue having to do with Memphis, was most timely.

I would endeavor to ask the staff to set the whole question in some type of framework, and then we would like to have Dr. Margolis comment on those issues, be conveyed to the staff and to perhaps some of the regions.

I think this is very timely, what he has done.

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REGIONAL MEDICAL PROGRAM REVIEW

MISSOURI

MR. CHAMBLISS: We shall now then turn our attention to a review of the application from the Missouri Regional Medical Program. The reviewers here will be Dr. McPhedran and Dr. Miller, and staff support will be provided by Mrs. Resnik.

Thank you, Dr. Margolis.

DR. McPHEDRAN: Yesterday Dr. Miller and I got some additional material on the Missouri application, and I cite this now not to beg off, because I have read it, in fact, but it was interesting because it was a staff visit to Missouri and it was suggested to me that maybe I ought to change my views to some extent. In fact, the value of this program and the merit of the application, specifically.

But I must say I think it hasn't changed my views a whole lot, and, while I've got more to say about it than I did, it really remains about the same.

To go through the review sheet: program leadership, I was unable to classify one of the categories, and have checked "satisfactory to poor" because I think that it is variable, without mentioning particular persons. I think that it really is uneven, and I'm basing this on the fact that the leadership seems to me very much the same as I recall it from at least two -- because I've been there twice --

two previous site visits, and a lot of discussion at various National Advisory Council meetings.

I really think that what has happened in this application reflects this leadership to a considerable extent.

I have no criticism to make of the program staff, and never did, except that I think it used to be very large, and the proposal suggests enlargement. I can't -- unless they postpone the marking of that enlargement, it is currently 30 with a proposed addition of 45 staff.

The program staff in the past we used to criticize, maybe this should have been more a criticism of the leadership, for its lack of initiative in helping people in the region to develop parts of the program, develop projects and develop other component parts of the program.

According to the most recent visit, that is not a problem now, but it certainly used to be.

I am persuaded by the recent visit, I have said that at least it's satisfactory, but I really wonder whether, if it's satisfactory now, it is justified to consider all the additional staff to such an enormously large staff that is proposed.

The Regional Advisory Group which, until a couple of years ago, numered only twelve, has been increased, I think, by two stages to a total of 55 members, and it appears that

it is satisfactorily supervising the activities of the program. In the fourteen months before this application there were four Regional Advisory Group meetings, I think eight of the Executive Committee, and several of the various technical and standing committees.

So the committee structure has continued to function and the Regional Advisory Group also said that there is a fifty percent attendance rate at these several RAG meetings.

Past performance and accomplishments, I think are mediocre for the most part. I found it difficult to either say satisfactory or poor or inadequate.

Considering the amount of money that this program has gotten in the past, it is difficult for me to be more generous in my assessment of this.

In the past there was a very large investment made in a lot of computer centered activities, and I guess that this still remains with me, although it's all gone from the present application.

We thought, those of us who visited it, that there was bad judgment and even, perhaps, appropriate for the State of Missouri , mulishness about following the direction and guidance that we attempted to give.

The objectives and priorities seemed to be satisfactorily stated.

I think that the proposed activities, and I can

summarize briefly the categories are satisfactory but not imaginative. The feasibility, that is, the likelihood that the activities proposed can be accomplished in the time that they anticipate the program will continue is, by their own statement, likely in some and unlikely that they can manage in others.

For example, they state that all the EMS activities that they have proposed, and I will come back to this, there is a question pertinent to the one Dr. Scherlis raised earlier, whether or not these are new EMS activities; but they say that they feel these activities can be upgraded in the next year. I really wonder whether that is so.

The cooperation with CHP seems to be quite satisfactory.

My over-all assessment of the region is that it is only average.

I am afraid I have more comments and remarks to make.

In this Regional Medical Program there appears to be no serious problem in the relationship of the grantee, which is the University of Missouri, and there never has been, and that continues to be, I gather, a satisfactory relationship.

MR. THOMPSON: You don't shoot Santa Claus.

DR. McPHEDRAN: No, not intentially.

The major thrust that they have stated for themselves are five: emergency medical systems; health; manpower; education, and under that category especially training people to deal with the problem of high blood pressure, and training seminars to be conducted for many categories of hospital personnel.

Third is listed as integrated health care delivery systems, with especially heavy emphasis, as I see it, on supporting hospitals in developing JCAH type criteria, and also a problem of oriented records for local practitioners.

Ambulatory care systems, particularly concerned about availability and of care.

The purposes, the major thrusts are as general -- I'm quoting from the application there; just general, as I'm stating them to be -- systems for end-State kidney management.

Their fiscal year '75 suggests that their EMS role will be completed, and the local communities will be able to take the developed programs and projects and handle them on their own, although I don't think that my reading of the application particularly supports that.

Then I went through the request for funding, including changes in core staff. I spent less time, I must say, on the continuing projects, but a good deal of time on the new projects, and tried to dig out for my own

purposes what I thought was a necessary expansion of core staff. And what I questioned might be new EMS projects, and I realize the staff might have gone through this and may want to, perhaps, dispute my judgment.

The excisions that I performed enabled me to cut their proposal from $3,010,113 down to $2,295,113. I felt that there was $713,000 that could and in my view should be removed from the proposal; and it happens to coincide with what staff, in the person of Mrs. Resnik, has recommended; and I guess it also coincides to some extent with the targeted amount.

But I think it is worthwhile to suggest what specific things there were.

There were, for example, requests for what amounted, I think, to increases in core staff. They have six district consultants, and the recent staff site visit suggests that they should be continued. I have no quarrewl with that. But there is a suggested sum of $31,000 by sub region to increase staff support for the distrist liaison to $186,000; and I will quote from the application what the ultimate justification is.

It is said that the specific outputs would be a plan and method of implementing the plan to operate under the new legislative athority. If no legislative authority is forthcoming by fiscal year '76, this year's effort will

have been one of which the Missouri Regional Medical Program can well be proud. We will have brought together at the working level members of principal federal and State health agencies, to work toward a common cause of improving the Statewide health care system, and I think that I would really have felt that even in a Form 15 something more specific than that could have been given me as a peroration to convince me that that money ought to have been spent.

There are other things in there that I feel are similarly if not worthier of support. I won't bother you with the details, but I do want to mention that I thought that there were about around twelve, as I see it, new projects, no EMS, twelve, roughly, totaling around $245,000, that I just don't think are in the guidelines, are they?

MRS. RESNIK: We're treating them as sub-components of already existing and ongoing EMS projects, which is essentially what they are. They are dealing with training, but in different locations. And they tell us that they understand that that is within their authority under the present guidelines.

They are applying to the EMS bureau, but they don't foresee any grants.

DR. McPHEDRAN: This looks to me like new EMS, and so that's 245,000, and then going through some other projects, I noticed this, but I did it anyway, I thought there

were several things, like there's a quality criteria project in a hospital in Jefferson City, and it looks to me as if that really is PSR activity, and I wonder if that similarly should be excluded.

And several other things that also seem to me unsuitable.

So that, in summary, what I did was I felt that at least $715,000 could come out of it, and I came out with a recommendation, as I say, of $2,295,113, which is obviously unreasonably precise, but it is approximately where the targeted sum is. I would have no quarrel if we said the targeted sum would be satisfactory; and I would like to know what Dr. Miller thought about it.

MR. CHAMBLISS: Dr. Miller.

MR. MILLER: This is an interesting experience we all go through. I pursued a rather different and more devious route of arriving at the same conclusion.

I have known the Missouri Regional Medical Program for a long time and many of the staff people on it, and perhaps it is worthwhile to mention a little of the background on this.

When RMP got started, Missouri was really ready, because Missouri was more regionalized in the medical establishment than most any State in the union, having their medical school in Columbia, which is a small, a relatively

small city, and therefore, having had to farm out clinical medicine for a long time into other communities, which is almost never done in most of the other medical centers in the United States, and which was extremely repugnant to them, as you may all remember.

So Missouri was, its time had come, and the mule characteristics recognized this, and they proceeded with vigor.

They also had some people in the leadership position who have considerable skill in recognizing political expediency, and when it is popular at the national level to spend money on electronic computer equipment and remote control things, they were in there for millions and got them. When it is politically expedient to turn them off, they turn them off like it was a water faucet. Which they have now done, because something else is politically expedient.

I have four applications that are mine that are coming up today, all of them are somewhat similar. And Dr. Schleris' comments previously have bothered me, yesterday and today and last night, and even lose a little sleep over it.

Because the principles formally ascribed to Regional Medical Programs of quality programs, well evaluated, demonstrations that are woth the money, seem to be all gone, and I suppose it seems a matter of political expedience, but

it looks like we're stuck anyway. But it is bothersome. And in these four programs that are coming up, they all have applications, they are going gung ho for election, it's politically expedient to get the money and they're out to get it. And by whatever most clever mechanisms they felt could be used to get it, regardless of whether it is cost effective or will be continued really, or what the ultimate goal is.

Now, Missouri has done it to a rather great degree. It has -- it doesn't have an escrow item in here, a developmental fund item, but its method will give it a nice big one.

There are separately described staff component projects, 26 of them in this application, either with a dollar amount, none of which is excessive by itself; but together is nice.

There are six district liaison systems with a total budget of $186,000. They went all out on EMS without having a general State EMS plan, which is forbidden, so there are five continuations and eleven new EMS projects, for a total of $518,000.

It would be some little job to keep them coordinated. Maybe they will need those district guys to keep all those different outfits working in any kind of a rational coordinating way.

I could go on in more details, but I think I will

say, first, however, that a little bit in contrast to Dr. McPhedran's view, I feel that the basic questions that we're supposed to answer on this review sheet, most of them relative to other RMP's, you'd have to grade Missouri as good to excellent.

The program leadership, you may not like them, but they've done a good job in Missouri. The program staff is equally so.

The Regional Advisory Group, they get along with very well. It's a little funny, but it works.

Their past performance and accomplishments, they have been a leader in Missouri without any question. They have lead regionalization in Missouri to a phenomenal degree, and they have more general acceptance than many other regions.

Their objectives and priorities I would interpret as political expediency, and they have done it extremely well.

The feasibility, of course, is very low, because we are theoretically supposed to grade these things on whether they can do this in one year, and they obviously can't possibly do what they've got in this application.

They get along fine with CHP, they support them in many ways. So they will get good acceptance by them.

The total picture, 26 staff component projects and

27 continuation projects and 19 new projects.

Much of this is over-ambitious for one-year concept, and it looks like it cannot be accomplished.

My conclusion: I recommend funding, however, at the targeted level, which I think it is a way out of the dilemma of coming up with a dollar figure.

MRS. RESNIK: They are coming in with a $500 request July 1, they indicate.

DR. MILLER: We will address that two months from now.

MR. CHAMBLISS: All right, each of the reviewers has come up with a different amount here.

DR. McPHEDRAN: Well, I really didn't make that in the form of a motion. I have no quarrel with --

DR. MILLER: Oh, I wouldn't mind if he wanted to figure out how you can justify coming out with $2,295,113. I'll go along with it.

DR. McPHEDRAN: I will move the target amount, which is $2,364,333.

MR. CHAMBLISS: Is there a second?

DR. MILLER: I will second.

MR. CHAMBLISS: It is moved and seconded that a recommendation for Missouri be the targeted amount of $2,341,490.

DR. McPHEDRAN: I know you were probably semi-

facetious, Dr. Miller, in saying that the changing in the computer or the electronic program direction which had developed so many electronic aids to care that was turned off like a water faucet. In fact, that really wasn't so. It was damn hard to turn them off. I mean it really was hard. It took a great deal of effort and persuasion, and determination, and repeated visits, and Bob Toomey --

DR. SCHERLIS: It has not been turned off, the output has been changed.

DR. MILLER: Excuse me, I should make a comment. I have been through this with several other RMP's, some of which I made site visits on also as a coordinator.

I agree with you. The electronic fanaticism in our society is extremely difficult to turn off. We had it in many others. Georgia was a good example, when I was down there.

But it has been turned off now in almost all RMP's.

MR. CHAMBLISS: May I restate the recommended amount for Missouri as being $2,364,333.

Is there further discussion?

I call the question.

Those in favor of the motion, please indicate by the usual sign of voting.

[Chorus of "ayes".]

MR. CHAMBLISS: Those opposed?

[No response.]

MR. CHAMBLISS: The motion is carried.

DR. SCHERLIS: I ask one question now that you've voted on it.

This relates to the fact you said they had a great many different types of EMS activities, and you questioned coordination. Is that correct?

DR. MILLER: Very difficult to do this with this many separate components.

DR. SCHERLIS: You mean they are making no effort to coordinate it? Is there any umbrella EMS for the region?

DR. MILLER: No, no. They would hope to get one. But in the meantime they are going to have all of these various sub-components which are allowable.

MR. THOMPSON: Mr. Chairman, would you transmit our unease about the EMS situation in Missouri to the EMS people?

MR. CHAMBLISS: We will, indeed. We are much aware of the discussion here, and we will be in touch with the EMS people.

DR. SCHERLIS: I would almost suggest that we give no EMS funds if they are to be used in disparate programs.

In the State of Maryland we have had examples of what is now a large State support of some $2.4 million through

the Governor. In the face of what are already small EMS activities and some not so small, and you will spend endless dollars trying to coordinate what are programs that begin with noncompatible equipment, noncompatible standards, noncompatible operations.

And I would think that if we perpetuate such support, that we will be causing an excessive amount of funds to have to be spent later on.

Some training programs will differ, criteria for State certification will differ because you will be training at a different level.

I think part of the insistence that we should have would indeed be that these be coordinated, regardless of what the ground rules are. Otherwise, we should not support any EMS activity whatsoever.

I feel very strongly about that, having spent a good part of my energies in Maryland, because of the very reasons that we have had different types of funding, different community structures and different involvements. We would be undoing a great deal of what has been done in the past.

MR. CHAMBLISS: The EMS people are moving towards State plans and State systems, Statewide systems.

DR. SCHERLIS: But if you give money to that group, they will do their thing. The history of our society is

that everyone does his thing if he has the wherewithal to do it, and I would assume that by making separate structures administratively, with our own means of support, they will do their own thing.

I hope this won't be true of Missouri.

MR. VAN WINKLE: We did that in kidney, you know, Len. If that did meet with within the State plan itself, nothing was approved here.

DR. SCHERLIS: But we have this leverage over these programs, I gather from some of the feeling that we don't.

MR. THOMPSON: You see, the problem is that many of the States do not have State management.

MR. CHAMBLISS: A good amount of our previous funding for EMS has resulted in the development of State plans. I can assure you of that.

DR. MILLER: Can I make some comments? I have been connected with this at the local level. Although I don't pretend to know it all, I know quite a bit.

EMS systems started out with an Office of Transportation funding, which is very large and many have them -- there are many of them in the United States. We happen to have a very large one in Minnesota. And they're buying ambulances. They are headed by ambulance drivers, by and large; they're buying ambulances and training ambulance

attendants, and setting up standards for their performance, and that funding is precluded from doing anything with the patient except delivering him to the door of the nearest hospital. It cannot go any further.

When EMS incentives started with RMP here a couple of years ago, why, the focus was to try to get comprehensive planning for comprehensive care of emergency cases, and to face the issue about what happened to the patient after they got inside the hospital door. And so many RMP's undertook to do this, and many of us supported planning for comprehensive emergency system development in the States.

Then EMS bill came through, and it seemed like that this was going to take over, the over-all coordination; but this, as usual, has not happened.

And the leadership there doesn't seem to have the capacity yet for attacking the whole problem.

So at the local level the possibilities of local B agencies or regions or districts within the State of getting funding through the new EMS bill was really quite remote and they came back to RMP in most of the local levels to do this.

So there are three separate fragmented kind of programs for EMS in this country right now, and they're not coordinated at the national level, and the attempt of RMP's is to try to get coordination at the local level, which we

have always been challenged to do in the RMP management system.

MRS. WYCKOFF: But if you offer them money and say, If you will make a State plan and you have this money, would this create a climate?

DR. MILLER: That's exactly what we did two years ago. Many of us did it two years ago.

We paid for the development of some kind of a State plan.

DR. SCHERLIS: Not necessarily. I was chairman of the EMS Committee nationally that reviewed all the projects that came in, and these weren't, except in rare instances, State plans. And I'd say if you look at the whole United States now, there are very few States that have any semblance of a State plan. Maybe two or three.

DR. MILLER: Now, there's a good difference between a good State plan and a State plan, so I'm not saying they're good; I'm just saying --

DR. SCHERLIS: My only concern here is that I hope in whatever letter goes out indicating funding that one proviso of that letter states that each of these areas have set up compatible systems, that there has to be a plan utilizing all their forces. I don't think that this State is large enough to have individual areas designated as they have, unless there is some over-all State compatible plan of

communications and everything else that goes into it.

I would think that unless we put that into whatever support letter we send out, this will be something that will have to be dismantled later on and will have to be fragmented. That's the only point of my observation.

MR. CHAMBLISS: We do appreciate these observations that the panel has made.

We have at the table Mr. Mike Posta, who coordinated the EMS activities for the RMP's, and he indicates to me that of the 23 site visits that were made by staff over the last year, that the majority of them had, as an effect of the RMP support, the development of State plans.

And we will keep in mind your admonitions for lessening fragmentation and more coordination between the three federal agencies that are supporting EMS activities.

I want to assure you that RMP has already been in contact with the Emergency Medical Service Program here, and agreements have been reached as to what we probably might fund and what their area of responsibility is. And I assure you these discussions will continue before these funds are awarded.

I would call to your attention --

MRS. RESNIK: May I add one word about the Missouri EMS program and the thrust in this application?

It was stimulated, by and large, by the passage of

State Law 57, which set forth standards and requirements for equipment on ambulances at various training levels, to the extent that these programs involve programs with little training, and that is the majority of the new activities, it is not new in the sense that they are treating a new aspect of EMS. They are training at various levels to conform, or their existing training to conform to the State requirements as described in the law.

And that is why it looks fragmented, but it is part of eventually a total training system.

I raised the question with them about equipment and various items of that sort, and there was still a considerable number of dollars that has to be looked into. But there was a major point in establishing these as separate activities to conform to the State law.

MR. CHAMBLISS: I think we have already had a vote on Missouri, and the discussions we have been having is an add-on.

I would simply suggest to the committee that it may wish to take a coffee break at this time; and, if so, maybe we could return at 10:30, 10:33 with our coffee and resume.

[Short recess.]

MR. CHAMBLISS: May I call the panel to order again, please, and indicate to you that I gather that the

other panel is moving quite well -- and so are we -- and suggest that we might take a look at the application from Nebraska Regional Medical Program.

Yes, Dr. Thompson?

REGIONAL MEDICAL PROGRAM REVIEW

NEBRASKA

MR. THOMPSON: I guess I am the only one.

MR. CHAMBLISS: Yes, you are the reviewer, and the staff support will be provided by Zivlavsky.

Will you proceed?

MR. THOMPSON: I will.

Nebraska has not been the most flaming RMP among the 53. It's relatively small in amounts of money granted. It never achieved triennial review. Its status has always been on an annual basis, although there were indications, I understand from staff, that they were going to apply for triennial review one month before the famous letter zipped down to tell them to phase out.

They have a new man there who has only been there, I think, a couple of months, about half time. I expected with his history a far less professional job on that proposal than the one I find before me.

Actually it indicates to me far more strength in the region than has ever existed before. I don't know exactly what happened to cause it.

I wish that every report we ever had did what Nebraska did very early in their proposal. There is Exhibit 1, goals/objectives, and they are fairly well spelled out. Both the goals and objectives.

What happened was that when they got the letter, the original RAG began to fall off and they then reappointed a committee for the phraseout, which consisted of selected people within RAG, and they began the phaseout operations, and then when the breath of life came back into the program they selected from this committee, the phaseout committee, thirteen people from RAG, so they only have thirteen people in their RAG at the present time.

However, when you look at the makeup of this committee it is very widely represented. They have a lot of public representatives, and they do have one Indian representative among the twelve, so there was an attempt to retain at least a Statewide representative RAG in this small group.

I think what we have to think, to regard this, we have to remember the goals, and the goals are not all that innovative, but they are good solid goals, and I think they are within their reasonable capacity of Nebraska to carry out.

One of them is kind of unusual, in that their Goal No. 3 has the specific objective to stimulate the development of comprehensive home health care systems. In other words, they have really gone all out for home health care systems.

Their goals, roughly, in broad terms, there is a

planning goal, there is manpower training goal, there is this goal of home health care systems. There's the data reporting analyzie kind of goal. And then the last goal is the facilitator, coordinator, gathering people together kind of goals.

But in each one of these broad goals there are specific program type objectives.

And one must say that there is a very close relationship between these goals and the kinds of programs that we see coming up in the proposal.

Now, at the present time, they have been operating at a level of 502,000. I said they are one of the smaller programs, I think they are one of the four smallest programs, as far as money is concerned.

Their target would be some 868,000. This package here is 962,000 with an indication that they will be coming in with an additional request of $150,000.

So we then have a program that is kind of climbing up beyond their original base level support. The program that probably would have gotten triennial approval, if the funding thing hadn't changed.

Now, in general, they -- the most recent change in this program, as it has been with most of the other programs we've seen today, was their relationship with CHP. They decided to start working with the various CHP agencies within

the State, and they have more or less redefined their mission within -- still retain their goals.

Therefore, on Nebraska Regional Medical Program, its mission is toward cooperative work with A and B agencies in Nebraska State Department of Health, in an attempt to match those health care providers who have a need for service with those resources capable of responding with services with the ultimate purpose of improving the health care, for all Nebraska citizens.

So that this is kind of a redefinition of its own mission, vis-a-vis the CHP agencies. It is not all too clear from the proposal how well this is progressing.

Several other projects that we will be talking about actually came from B agencies, and in one B agency right off they said it would be unfair for us to write off on this, because actually we were involved in gathering the proposal and designing the proposal.

There are other sections where there is an absence of a writeoff or a signoff by B agencies or A agencies, and others where the A agencies and B agencies in particular indicate a very positive view toward the projects.

So it's kind of spotty. I will try to have the staff elaborate on this, because, although it's evident they are trying to cooperate, how successful they are is a whole nother question.

Now, when you look at the proposal, and it's probably the thickest one in this go-around, it seems rather awesome until you realize that it is a fairly simple proposal. They put their money on two things, an A hex kind of a business which they believe should be, like Memphis, to cover a fairly small region, and if you were concerned over the fact that some of these area community health-education consortia, as they call them here, or hospitals in Memphis, you will find some of them are nursing homes in Nebraska, because their primary concern is with that level of training.

So, of all the projects we're talking about, there's these two main thrusts, the A hex type thrust, with a nationalized learning -- I mean a Statewide learning resource center, and then some one, two, three, four, five, six specific regional agent type outfits.

Surprisingly in this proposal, there are eleven different home health proposals, home care proposals, some of them defined in one way, home health satellite or the day-care service for elderly and disabled; and they have these scattered throughout the State, mostly based in nursing home type places. They are trying to get nursing homes for whatever few little bits and pieces of visiting nurses' associations they can find, and beginning to design a global home health backup program, for the elderly in various parts of the community.

And of course this is, as I said, these two thrusts are in line with their Goals No. 2 and No. 3; and the rest of this rather large list of variety of programs, nurse-physician programs in the cities, shared hospital resources, which are not unusual, they are all small. They run from 12 to 33 thousand dollars. It's obvious they're shoving this money into programs that are in existing institutions.

There is this problem of their renal program, which is the largest of all these non -- A hex non-home health related outfits. Which I will allow Staff to respond to, because it looks like a fairly shaky business, all in all.

I'd like to hear from staff. I'm going to use him, if you don't mind, as kind of a secondary reviewer, because my secondary reviewer isn't here. And let him particularly elaborate on the problems of the interface with CHP's and with the kidney problems, and any other comments he may have on Nebraska.

MR. CHAMBLISS: Mr. Zivlavsky, will you comment, please?

MR. ZIVLAVSKY: The Nebraska application is 576 pages. Dr. Hess, three years ago, made a site visit out there, followed up by a site visit approximately a year and a half ago.

There was a major shakeup out there. They followed up on many of the concerns from the first site visit. They

increased their program viability and they were just as any upsweep to come in for a triennial anniversary application when our phaseout letter hit them right between the eyes.

Some of the good things that they have been able to do have been their efforts in indirect costs, for example, have been less than five percent of their total costs. Over the past two years they have really been able to do a good job in this relationship. They receive a few stars for that, at least.

In the area of minorities, the State has approximately 2.7 percent. They have worked in the area of sickle cell screening for the entire black community of Lancaster County, which is in the Lincoln area. They have worked with a mobile cancer bus in terms of screening the Indian population.

The program staff has provided assistance to the Panhandle community action, which involves the migrants and Indians out in western Nebraska. In their phasein they have hired an additional minority -- I should say they lost one minority person in their program staff. They were able to hire another minority person on their program staff.

I am not sure -- they come in with an application requesting no people. Presently they have 11.5 full-time equivalence. I think they can use a couple of people to help them in the monitoring area.

I don't know. That's up for discussion or grabs, I guess.

I like the comment on the negative CHP comments, and on page 345 of the application, specifically commenting on Mr. Thompson's CHPA comment, the reason the CHPA agency withheld comment was because they developed the proposal and they were actively involved, and I believe they felt it was a conflict of interest. So they backed off, and this was one of the reasons that they did not comment.

The second negative comment is on project No. 47, and again the CHP agency has commented that this project lacks specificity.

The program staff is following up on this particular project, and it involves the Omaha and Winnebago tribes, and basically there's a misunderstanding that the outreach from the community health representative in the community population, the CHR's, they assume that you have much more time than really is available; she has a half a day a week for outreach activities, and they didn't really get this clarified before they submitted the proposal to the RAG.

The RAG again is following this up with program staff and I think they can negotiate this difference.

The renal project, DRMPS, Dr. Mathis, the present coordinator, if he would not seek out-of-State technical consultants, and he agreed to do this because all the people

within the State of Nebraska have been involved in their project.

Yesterday we received a letter from the associate coordinator for program services, attached to three comments basically from the technical reviewers. All three had negative technical comments, reducing the budget from approximately $51,920 down to 15 or 20 thousand dollars.

These comments have not been submitted to their regional advisory group, however. The Regional Advisory Group will be meeting this following Friday, reacting to these negative comments.

Basically what you have is a questionable stance. We are trying to ask the community for some suggestions or recommendations on what to do with this particular project. I think I have answered.

MR. THOMPSON: My funding recommendation, they are now 502, the target is 868. This comes in at 962. There's a possibility of another 150,000, because there is really no slush fund or escrow, however, designed in this program. All the money is carefully identified in this, these little small programs.

It is very difficult to cut much of this, but I would make the recommendation they be funded at $912,000, which is $50,000 less than they now have, which reflects their cost of that kidney program, which I have some doubts about.

I am not going to tell them that this is against the kidney program, but they've got to read. The kidney program has cost 50,000, we're cut 50,000. And they still will be the third smallest program in the country if they get all this.

DR. WHITE: Well, in the past we could say these technical experts came out. If you go ahead and insist on each of these, inspite of our advice and their advice, next time around;they can thumb their nose at us this time, because --

MR. CHAMBLISS: Would you speak just a little louder, please?

MR. THOMPSON: I think the technical comments on this -- I can't see how the RAG can step around them. It was unanimous, and I think the RAG will just drop that.

So I think we can put a little hint in the advice letter.

I move, then, $912,000 for the Nebraska proposal.

MR. TOOMEY: Second it.

MR. CHAMBLISS: The motion has been properly moved and seconded.

Is there discussion, please?

Question.

Those in favor?

[Chorus of "ayes".]

MR. CHAMBLISS: Those opposed?

[No response.]

MR. CHAMBLISS: The "ayes" have it, and the motion carries, at a recommended level for Nebraska of $912,000.

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REGIONAL MEDICAL PROGRAM REVIEW

NEW MEXICO

MR. CHAMBLISS: Shall we then move to New Mexico? The reviewers here are Dr. Miller, and Dr. White, with Mr. Zivlavski as staff support.

Will the record so indicate that Mrs. Jesse Salazar is not a part of these proceedings, and has absented herself from the room.

DR. MILLER: The New Mexico application is another of the umbrella type RMP applications.

It is an extremely ambitious one, and has an application for $2.77 million, when the current level of funding is $1.2.

However it does not plan to come in with another application in July, so this is its total application for the next year.

The New Mexico RMP had -- has a new coordinator, and who starts, let's see, May 1st. Dr. Gaye, who has been, in my opinion, an able coordinator in the past, is resigning as of the 30th of June, but will remain as a consultant to Dr. Walsh, the new coordinator.

Otherwise, the program leadership seems to be good, and I presume that this arrangement looks like it will still provide a continuity and a fairly stable program leadership.

The program staff seems to be adequate, and capable

in general.

The original Advisory Group, I don't quite know what they did -- why they did what it did. I couldn't find it in there, but they recently padded the Regional Advisory Group, increasing its membership to 120 people.

And we've seen that in reverse a number of times in the last few years. I don't know what will motivate it doing this.

But, of course, it forced the development of sub-committees to then run the program, and at least it seems to be reasonably satisfactory.

The past performance and accomplishments have some bright spots, and some that maybe aren't quite so bright. But in general they seem to be satisfactory. As I felt their objectives and priorities were, also.

And the proposal is congruent with the explicit objectives and priorities as given.

The feasbility is another one of these where, with the tremendous proposal for a year, it doesn't seem very likely that it can carry out well the projects that it proposes.

CHP relationships apparently are quite good.

So, over-all, I felt the program is above average. And I felt that the -- that if RMP was going to be continued for another three years, this region, like two or three

others we've had yesterday and today, would be really well-established for going gung ho ahead on a three-year program.

Most of the projects in this application are really projects for the staff. There's some confusion in my mind as to what constitutes a staff program in New Mexico and what constitutes an extramural project, since, in most of the projects, why, the RMP is the, apparently the sponsoring organization, and many of the staff that are going to be working on the project are staff people of the Regional Medical Program.

So I interpreted all except two of these projects to actually be essentially staff activities. Which, in this case, would mean, then, that almost the whole program in New Mexico is a program staff management system of staff and projects run by the same people.

There are two projects that are extramural, which they list as the lowest priority, in which it received some unfavorable comments. So that -- which are for a neonatal regional program and -- I forget what the other one was. Genetics. Oh, yes, genetics regional program.

There's one huge emergency medical service that is an expansion staff project, continuing -- it's a continuation project, but it's a huge expansion, with a budget of $911,000. Same kind of problem we had before.

I don't know what it was last year. Does the staff

know?

DR. WHITE: We're trying to determine that right now. That kind of information is not in any of our research.

I think since the program is funded to July '72 for $520,000.

DR. MILLER: $528,000? Well, it isn't such a huge expansion.

DR. WHITE: Well, that was for two years.

DR. MILLER: That was a two-year program.

DR. WHITE: That was two years?

DR. MILLER: That was two years of funding?

DR. WHITE: Yes.

Oh, this is one year, $911,000, and another one of their projects, health education for the public, was expanded to $303,000, and I don't know what the previous level of that was.

MR. VAN WINKLE: Project 25.

DR. MILLER: No. 25, health education for the public.

MR. ZIVLAVSKI: There is another substantial increase. They had $175,000 in there, and then about 70,000 for the past six months. And they put approximately 225,000 in there.

DR. MILLER: I have some philosophical feelings

about health education for the public beamed through every possible communication mechanism for one year for $300,000, as to what are the cost-benefits, and how would you ever know? And if you can't know, what the devil do you do it for?

MR. CHAMBLISS: Dr. Miller, I think in all candor, with the reviewers, it should be noted that we had a staff presentation of that project, health education to the public, during the last year. We were not overly impressed with what came out of it.

I say that just so the committee may know that that presentation had been made to the staff.

DR. MILLER: I think I can complete my statements now with the feeling that this is an over-ambitious, largely staff programs in an RMP that is fairly good, and therefore my feeling is that we ought to hold our funding to the targeted level.

MR. CHAMLISS: Dr. White.

DR. WHITE: Well, I noted that Dr. Gaye was retiring. I don't know Dr. Walsh. I know nothing about New Mexico. This is the first time I've had anything to do with New Mexico, other than the site visits as a reviewer.

Dr. Walsh is an unknown quantity, to me at least. The staff seem to have the credentials.

My interpretation of the Regional Advisory Group is

that it was ex panded to 120 people in 1971, at whose behest I don't know, but possibly to get the minority group in, or one thing or another.

But, in any event, when the phaseout came out, they then began reducing by attrition, and beyond that they also began not meeting, to my interpretation, in delegating their authority to an executive committee and I think this is reflected in the fact that the proposals, as I read them, are enormously impossible.

If they had trouble spending -- I think it says in here the number of people they trained in two years in the EMS program for approximately $250,000 a year, they have no earthly hope of spending 900-some thousand in a year's time and getting their money's worth out of it.

I think also that health education to the public is a hopeless proposition by the avenues that they propose. I don't why we can convince people to take aspirin by using mass media, but we can't convince them not to take it.

MR. THOMPSON: Well, you know, Bayer's advertising budget is far beyond anything we put out.

DR. WHITE: In any event, beyond that, I would agree with Dr. Miller. I would consider this an average, neither bad nor good; and I think it's entitled to its fair share of whatever money is portioned out, and I would agree to the targeted fund minus whatever is reserved for July,

and let it go at that.

MR. CHAMBLISS: Dr. Scherlis.

DR. SCHERLIS: I looked at the Emergency Medical Services, which constitute a great part of their budget, and in reviewing it, I asked some serious questions about it. It looks at what is the easy side of the Emergency Medical Service, the trainee and the vehicle end of it, but in terms of looking at a system of care, there are some serious questions.

Maybe I could just spend a minute or two on this.

Under objectives, it looks at training and communications, which really consisted of developing a statewide emergency communications system linking all hospitals and ambulances together, then to create a crisis center to integrate all communication links.

I guess the question I have is something that maybe they have not included in this, although they have about 40 or 50 pages devoted to it, and I would rather see that than all the individual sources, and that is, are they are talking about characterization of care?

I see the reference that this is an important aspect, but if you are going to have people talking to people, they should talk to them about something aside from the fact:

"We're coming in in a hurry; we've got some sick people aboard."

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I don't know if they provide in there, and perhaps Staff can comment, whether they have provided medical communication at one end or whether this is administrative communication.

Also, if they are under all of these funds proposed for centers in the state for treating more specifically certain types of catastrophic events, if they are talking about one or twenty burn centers, one or twenty trauma centers, one or twenty cardiovascular centers -- so what is "Training and Communication Evaluation," and I would have to review tnis carefully, but I would think one would like a great deal more in the way of evaluation than what they have included, if they are going to get some answers in terms of what they want to do.

Continuity -- they are going to ask the Governor for money, which seems to me the best way to continue all forms of care, at least by going through the appropriate motions. But I don't see adequate emphasis in here on what I would think seem to be the real problems despite the fact they are putting in an awful lot of money.

They are talking about basically new and better ambulances, about communications, about training, and I think the other end of it, in terms of what happens when these people get to a center? I don't know if they are talking about by-passing certain areas, or if they are talking about

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really having hierarchy type of care and really a regional type of emergency system. It does not seem to come out of, at least, the document that we have, and I question whether or not this is really an adequate presentation or whether you know more about their plans.

Maybe this does not do justice to the plan they have. I don't think that this warrants the price-tag placed on it, at least from the minimal review I have given it.

Perhaps you can comment?

MR. CHAMBLISS: Are there Staff comments in response to Doctor Scherlis's query about New Mexico?

MR. ZIVLAVSKI: Why don't I just start from the top and make a few comments?

In terms of the RAG and the number of the RAG, when Doctor Gaye became Coordinator, it was his decision to involve more people in the decision-making process. He increased the RAG 220 members, broadly representative and including minorities and parts of the state, and the whole thing.

In this application it seems like a conflict of information, but in the RAG report it mentions 120 still being there, but actually they have decreased it to 73 members.

There is a little confusion in interpretation; it depends on which page you look at. The -- in terms of the -- of Doctor Miller's comments on whether there is confusion over staff projects, and are they essentially control projects,

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four or five of these activities were out originally with CO numbers. The last review we had, in a site visit we had down there, we indicated to them that what they needed to do was to place these projects in independent status, provide them with a project number and make sure you give them the -- the information to the Project Directors that these are unlimited activities and they can't crawl back into the wings of the university once the project phases out.

Just in the last six months, they have typed these CO type numbers and have been able to communicate these to the people.

These are free-standing, they are centrally located in the headquarters of the RMP, physically right in the same area. However, they are operating as project directors, 100 percent type of activities; when the project ceases, they are going to have to find new employment, whenever that happens.

DOCTOR MILLER: But they are staff of the RMP; they are listed under the personnel lists for each one of those things as the New Mexico RMP staff.

MR. ZIVLAVSKI: There is no duplication in terms of salaries on the Form 6, which is the core staff salary budget, as well as the Project Directors' salaries. There is no duplication of funding; each of the moneys are coming out of different types of activities.

WHD50

You can look at Project 32, the community health resource development, Project 33, the health resources registry, and Project 34, regional health resource plan and development; each of these three projects are leaning toward the future of health resource planning.

These are not in escrow, there is not -- these are defined moneys and they tell you exactly what they hope to do in these areas.

Staff did -- there was a presentation by Project No. 25, which is the health education for the public; it has substantially increased their requests. This is a statewide project; the former project director of this is now a Deputy Director of the RMP.

It presents a problem; maybe the alternate suggestion is to have a technical review committee, site visit from out of state consultants to come in, people that don't have a bias, and maybe we could send this message back and then write an advice letter to the program to have somebody from out of state come in, let the RMP pay for it with their own funds, then give the report to the Director of the program -- not to Walsh, not the Deputy Director, who is the previous Project Director.

Project Number 18, EMS, there is a heavy emphasis -- they have done a lot of things in here; I don't know how to tackle some of your questions, but you mentioned the fact of

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categorization; the Deputy Director, Doctor Hanratty, has been working on a computerized system for it.

Their position is that they are not happy with any of the national plans for categorization, AMA or any of these. They would like a modification of each of these plans, and they would like to have a computerized categorization of the hospitals. And they are working on that right now; they started out slightly on their surveys, the form has been prepared. I can't tell you what modifications have been made in the categorizations of all the hospitals, but there is an obvious gap, because one or two hospitals in Albuquerque, one in Santa Fe, and then you have the rest of the state, and they haven't completed this. They have the survey form developed.

It is a modified form, and what the results will be have not appeared yet.

In area medical communications they work closely with the State Department of Communications. Everything they do there is pretty well based on a total effort, because there are a lot of scant resources.

They have done quite a job in terms of training. No RMP funds have gone into the purchase of vehicles; the RMP -- Doctor Walsh, by the way, the present Director of this Program, is also the Director of the EMS project. If he is finally selected as the final Coordinator on July 1st, his

WHD52

Deputy Director, Doctor Hanratty, will -- it looks likely that he will take over as Project Director. He has been Deputy Director on the project for one year.

MR. CHAMBLISS: I wonder if that sufficiently covers the query about the categorization and so on?

DOCTOR WHITE: I might point out that if you take the targeted fund -- I was a little more charitable in approaching their EMS; I think they do have some compatibility in terms of their training programs, and by legislation they are going to be uniform.

Communication as I read it was between am bulances and hospitals, where there are enormous distances to get to.

DOCTOR SCHERLIS: The average run can be 50 to 100 miles.

DOCTOR WHITE: They need to communicate with the interim stations along the way just in case something happens.

DOCTOR SCHERLIS: This is why I asked about the categorizations, because I don't know how they are going to react to passing certain ones if they have to, and this is a key feature to a state that large, with a long haul.

DOCTOR WHITE: But regardless of the quality --

MR. THOMPSON: This is rather ironic. Unless I am mistaken, the first proposal that ever came in from New Mexico, altogether in the old, old, old, days was on emergency

WHD53

medical services. They did a rather large study and they found out that the primary cause of death down there was not heart, stroke and cancer; it was Indians spread out over the highway in these old cars.

We did not give them any money because they did not fit into the categories of heart, stroke and cancer.

DOCTOR WHITE: It still doesn't solve the problem of the Indians, because they point out in here, there are no areas in which the Indians are terribly keen about participating in.

MR. CHAMBLISS: Is there a motion and a recommended level of funding here?

DOCTOR MILLER: I move that they be funded at the target level: $1.64 million.

DOCTOR WHITE: Second.

MR. CHAMBLISS: It has been moved and seconded that New Mexico be recommended for funding at a level of $1,644,000.

Is there discussion on the motion?

All in favor?

(Chorus of "Aye")

Opposed? The level is recommended at $1,644,754.

DOCTOR WHITE: They will get the message about staff appraisal of educational efforts, won't they?

MR. CHAMBLISS: Your concerns will be passed along, indeed, regarding EMS and education for the public.

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REGIONAL MEDICAL PROGRAM REVIEW

NORTH CAROLINA REGION

MR. CHAMBLISS: Shall we go on then to North Carolina?

Doctor Miller, Doctor McPhedran, and Staff will be represented by Mrs. Parks.

DR. SCHERLIS: We should have Mrs. Salazar come back, shouldn't we?

DOCTOR MILLER: This is another large application. North Carolina has a current funding level of $1.67 million, it puts in an application for $3.26 million, and plans to submit another application in July for $400,000.

Targeted level is $2.78 million, and the composite of the present application with the proposed additions in July will be 132 percent of the target, or $880,000 over the target amount.

The Region is a good Region, in general, has done a lot of things in the past that are quite outstanding. They have a change in the Project Director and Coordinator, which I can not assess. Perhaps the Staff can help us with that.

The new Executive Director, Ben Weaver, was Deputy Director for five years, so it is presumed that his leadership should probably be adequate.

The program staff approach looks all right; they plan to increase it quite a lot during this next year, but

WHD-2

they have a fairly good nucleus anyway.

The Regional Advisory Group assessment is all right.

The past performance, as I mentioned, is good; their objectives and priorities are good, and the proposal fits in with their objectives and priorities.

Their CHP relationships are good.

This, in my opinion, is one of the extremely needy areas in this country, where you can hardly design anything that would not help, because their needs are so great, and they are really deprived of health care. There are many areas of health care deprivation in services, and they have been working toward these and have made some outstanding achievements, I think, in this area.

So I think they deserve a recognition of those things.

They have, in this application, 45 projects. A lot of them are not very good in principles of feasibility or performance, and are not in my opinion, justification for the costs.

One continuation, one which bothers me terribly, but I guess it's just one of those things, is a medical air operations, which is $50,000, which is a continuation, so I suppose they have been doing it, which is solely for the -- the money is spent solely for the purpose of flying faculty, students and staff around the state in private planes in

JHD-3

support of the area health education center project.

Of course, all kinds of faculty -- as well as students and staff -- would like to fly in private airplanes almost anywhere if you give them that luxury.

Another one, they have a project in here for the medical foundation they have in the state for a PSRO development for $125,000. I think this is inappropriate; PSRO's are going to be funded, and as near as I can tell from that application, it is a pure PSRO project development.

Then there are multiple rural health clinic supports. There are supplementary support to state clinics or state rural health clinics, which undoubtedly are needed, and are supported by the state. But the amount of this support amounts to $243,000 altogether.

And then another supportive project for supporting the area health education center activities in the state, which is funded outside of RMP, to develop a library network for $363,000 in community hospitals throughout the state. Although I don't question their statement that community hospitals have no library facilities that amount to anything, and when you want to educate health-care professionals in rural communities, why, one of the things you need is a library, but it seems like an overly ambitious approach without any guarantee that it will be continued.

Another of the fundamental things, of course, in a

place like North Carolina, which I think is probably true in some of the other similar types of states, there is very little guarantee that these -- any of these activities will be continued after RMP funding, probably because, however, that their potential for funding things is so poor that they are quite dependent upon Federal funding programs.

In general, I regard this as a superior program, and it is a terrifically needy area, where they -- a composite application which is over-ambitious, and some of it is inappropriate, and my recommendation would, again, be a funding at the target level.

MR. CHAMBLISS: Doctor McPhedran?

DOCTOR MC PHEDRAN: I agree. I really have nothing to add.

DOCTOR MILLER: I'll make the motion, then.

DOCTOR MC PHEDRAN: I'll second that.

MR. CHAMBLISS: It has been moved and seconded that North Carolina be recommended for funding at the targeted level of $2,775,522.

Is there discussion on the motion?

DOCTOR MILLER: Their present funding for the current year is $1,175,000, so they will get --

MR. VAN WINKLE: About $1.1.

DOCTOR MILLER: They will get $1,100, 000 more money; they probably can't spend that either.

DOCTOR WHITE: Well, I guess that is what bothers me, in terms of losing out on a million dollars.

Even though you said it was a superior Region, yet I look at -- what? 45 new projects, which --

DOCTOR MILLER: Very needy. How do you really decide on deprived areas? There is no way to solve those problems without pouring money into them.

MR. THOMPSON: They are going to come in with another $400,000.

DOCTOR WHITE: Let's not get people used to something -- why get the poor people out in the hills used to something they are going to lose next year?

DOCTOR MILLER: Reminds me of a site visit I went on a couple of years ago to West Virginia. Have any of you been to West Virginia?

We were questioning a lot of these things, and one of the physicians said:

> "We depend on Federal money for a living; we will do anything -- whatever the Federal money resource requires, because we are totally dependent upon Federal money."

DOCTOR SLATER: They are not the only group that says that.

MR. CHAMBLISS: Doctor Miller, may I just ask a point here, about the PSRO? Did you say that was out and out

PSRO?

DOCTOR MILLER: Nearly as I can tell. Does the Staff have any other interpretation?

MRS. PARKS: We thought the same way.

DOCTOR MC PHEDRAN: I agree.

DOCTOR MILLER: I think it is totally inappropriate at this time.

DOCTOR SCHERLIS: I have some concern, because I think in your description of the various projects, programs and so on, I was detecting a certain note of lack of enthusiasm, and then I had your conclusions, which reflected, in a way, a disparate approach.

You know, the need is there, I think we would agree; the RMP has a pretty good track record, and again I would assume that, given an area that is impoverished in many ways, these funds might eventually do some good.

I do have a significant concern, though, in terms of all that money, in view of what I think were very apt criticisms of the ability to really spend this wisely, and I would think, particularly in view of the fact that they are coming back for at least additional funds at $400,000, and in view of the fact that we doubt very much that all of this can be -- not just efficiently spent, but let's say inadequately spent, that you might then entertain some reduction from the target figure, understanding that they are going to come back

for more, although I know that is not a constraint, but I just have some difficulty, as I view the large array of projects, particularly the one for, say -- well, I guess it would be $362,000 for a statewide network of hospital libraries.

I wonder if you might not entertain the possibility of reducing that some, because I don't think they could really effectively utilize this support level.

DOCTOR MILLER: I judge on that library business they are going to staff those libraries? I could not tell in the application, but they are probably going to set up libraries in every one of these hospitals, which has nothing now.

Is that true?

MRS. PARKS: Right. They will be tied into the nine area health-education centers, but I don't think that the supportive personnel will solely be funded through the North Carolina RMP.

DOCTOR MILLER: Well, it costs a lot of money to set up nine libraries.

DOCTOR WHITE: Doesn't it cost a fair amount to keep them going, in terms of personnel?

DOCTOR MILLER: It is a terrible problem. She says they are going to keep them going; will the hospital undertake the responsibility, or the AHEC, or solely someb ody else, for

the operation of these libraries after one year, after the RMP is gone?

DOCTOR WHITE: If nothing else, somebody has to dust the books.

MRS. PARKS: I am not really sure. The only information I have is what is in the Form 15, and it was not clear as to how many would.

DOCTOR MILLER: It does not say; there are a lot of unanswered things as you read these.

DOCTOR WHITE: Did you find contributions from the Appalachian Regional Commission? Matching funds and things of that sort that look as though they might be substantial?

DOCTOR MILLER: I don't think they have that in here, do they?

MRS. PARKS: No.

MR. THOMPSON: What I can't understand; they have been working specifically with hospital libraries, hospitals and quality control for all these years. What the hell have they been doing? All those small hospitals; that was the main thrust of the project -- quality control and libraries.

DOCTOR VAUN: The objectives of the National Library of Medicine is not to perpetuate the old concept of libraries. It does not cost a lot to build a library that can function through the National Library of Medicine network, and if we pour this amount of money into creating a lot of old-fashioned

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libraries, you might just as well flush it down thedrain.

MR. VAN WINKLE: Staff had flagged that for that consideration.

DOCTOR MILLER: Well, I think cutting the budget, even to the target level, will put the pressure on them for some of this kind of stuff.

MR. CHAMBLISS: That is the motion, to recommend funding at the target level.

Is there further discussion?

DOCTOR SCHERLIS: May I move an amendment to the motion?

MR. CHAMBLISS: You may indeed.

DOCTOR SCHERLIS: I withdraw my motion.

MR. CHAMBLISS: Those in favor of the motion, let it be known by the usual sign of voting.

(Chorus of "Aye")

Those opposed?

(No response)

May we have a show of hands on that vote, please?

(Show of hands.)

Three in favor, and the "Nay's" have it and the motion is not carried. The Chair will entertain a new motion.

DOCTOR SCHERLIS: I would move that the target figure be reduced by $400,000, as the level of funding for the coming fiscal year.

HD11

the vast array of projects, particularly that one, and to think in terms of what will happen to a statewide systems when you have libraries in individual hospitals, and what will occur at that time.

I think there is a lot of fat in this budget. I don't think this is going to affect their overall program one iota, and I think to fund them at their target level now, when they will be coming back for additional funds, they aren't bound to ask for only $400,000; I'm sure they will be asking for a significant sum more -- I'd like to give them that latitude.

Now, if you asked me if I reached a rational feeling, I think that I tried to express myself rationally, but I would suggest to you that the input to that was about 95 percent gut reaction.

Is that a fair appraisal? That's what you thought, didn't you?

DOCTOR MC PHEDRAN: That is what I thought.

MR. CHAMBLISS: Shall I call the question again?

Those in favor?

(Chorus of "Aye")

Opposed?

(No response)

The motion is carried, to recommend a level of funding at $2,375,522.

DOCTOR WHITE: I'll second that.

MR. CHAMBLISS: The motion is now that the recommended level be set at $2,375,522.

It has been properly moved and seconded. Is there discussion?

DOCTOR MC PHEDRAN: I supported the previous motion, and I really feel it is important for me to say that this is another arbitrary choice -- so was the previous one.

I don't really know how you decide, and it is obviously arbitrary and I don't know how it can ever be intelligently decided. In fact, it can't be without a more detailed review of the projects.

So I think that I would like to know whether Doctor Scherlis would acknowledge that this is a really arbitrary amount?

DOCTOR SCHERLIS: Let me tell you the rational way in which I reached my decision. I sit here and listen to the reviewer with a great deal of care, because he is going -- has gone through the document more than any of us have, and must really have some expertise. And I get a certain flavor which I file away, I assume, somewhere in my brain.

Really, it is a gut reaction, and then as the discussion goes on and I try to relate what I have heard at previous meetings, to a particular state, what I did in this instance was to look at the sum they have asked for, look at

REGIONAL MEDICAL PROGRAM REVIEW

NORTH DAKOTA REGION

MR. CHAMBLISS: Now we will move to North Dakota.

The presenters here will be Doctor Slater and Doctor Scherlis; Miss Resnik will represent the Staff.

DOCTOR SCHERLIS: North Dakota, Mr. Chambliss, is the smallest budget RMP in the nation, of $367,746, and are coming back in with a request for $774,057, which is 132 percent of the anticipated target.

I would like to make a comment that there must be some kind of a leak in this agency, because despite your protestations that they don't know what the targeted figures are, North Dakota is so honest that they said:

"There has resulted a grant application figure that exceeds the target figure."

Which doesn't bother me very much.

DOCTOR SLATER: North Dakota also makes a point which I think will rectify that -- and I am abstracting here:

"We have considerable difficulty attracting physicians to North Dakota. Our image is ridiculous in view of the national situation."

I think they have some problems in this proposal which reflect that self-image. Quite honestly, I am concerned about their priorities, and there is not a thing, I believe, that we can perhaps do about this.

WHD13

Their image, in fact, is based on the fact that they have about 146 primary care physicians per 100,000 population, which is the lowest on the national scene, and their concern is that they need to upgrade their medical care system, primarily going in the direction of producing more manpower and increasing the education of those individuals, both professional and lay, who are already there in North Dakota.

As you know, there has been a major press to develop a four-year medical school, and I had the opportunity to visit North Dakota after the original feasibility study, to determine whether they would become a Region, and recommended to you -- what? In '67, I guess; Doctor Scherlis has been there more recently, so his information is better than mine -- but they now have been accredited for a four-year school, and are searching for ways to implement this.

Well, to get back to what they have been doing, they have, from what I can make out, a small, reasonably well-organized, active staff, and I will have to rely entirely upon other people's inputs to determine how effective they are.

Their program thrust, as I said, was in education and manpower.

Past accomplishments include Emergency Medical Care System; they have been able to produce 1,000 Emergency

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Medical Technicians, which has produced a number of one per 600 population, which is the highest ratio on the national scene. They are proud of that; they feel it makes a very effective dent, at least on attending to accidents and emergency problems.

In the second area of activity, the University of North Dakota, working their EXtension Service through the Medical School, and working in conjunction with the Public Health Department, and the RMP , have really been able to get engaged in a great deal of data collection and professional education -- continuing education programs.

There are four AHEC areas which are actively involved in the arrangement of local teaching programs for lay and allied health professional teaching people, and associated with this have been the arrangements for a great deal of travel by nurse educators as well as the bringing in of local physicians to become engaged as teachers in their own special areas of capability, for not only lay but allied health professional people.

So that by and large, I think they have concentrated a great deal on blanketing the state with a great variety of types of continuing education and special types of therapy for coronary care, renal, chronic renal disease, problems requiring rehabilitation of the handicapped and the like.

Now, where are they going, against this kind of a

WHD-15

background?

They have presented a series of activities here which -- in which I would like to indicate to you where they see their priorities, on page 16.

Their RAG is made up of 47 people, with nine representatives from Comprehensive Health Planning. I believe they work very closely with CHP, but I don't have any direct evidence of it from this proposal, except in the sense that the CHP people are involved in reviewing and helping set priorities on the proposals that go through.

They are asking for a series of projects, and I will just run through them and give you the commentary on them.

First of all, they are intereseted in feasibility study to look into the development of a residency program in internal medicine. This of course is oriented to getting the medical school off the ground. $13,775; this will put together committees, consultants and site visits.

They are particularly anxious in looking at Pittsfield, Mass., Rutgers University, Muncie, Indiana, I believe it is, who have been able to develop residency programs at community hospitals. They would like to develop a consortium of hospitals for the residency programs that emanate from the University of North Dakota.

The second project, small -- $9,620 -- a feasibility study to look into the potential for graduate programs of

VHD16

behavioral science related to family practice, and they are looking to the possibility of developing a Master's degree in behavioral technology as a graduate program, and also set up resources for marital counseling, child-rearing, sex counseling, addiction, dying, and they will do this through statewide meetings and consultations and this kind of activity through AHEC.

The third type of program is $400,000, a biomedical communications system connecting the four AHEC's, phase A and B are to go on during this fiscal year, first of all to study the feasibility and costs, and mechanics of this, and secondly to purchase the equipment.

After they purchase the equipment, by the end of Fiscal Year '75, they will then present a fiscal study to see whether or not it is possible to continue to fund this, and that will go to the legislature, later to be in fact picked up and operated by the University of North Dakota.

There is really no mention of the -- apart from microwave connections and a few general words -- there is no mention of the kinds of equipment, how the terminals will operate, what the details are, how the people will fit into this -- now many specific types of programs will be functioning through the learning centers that will be located in these four places.

By and large, I don't understand this and am very

concerned about this type of expenditure of money.

I bring this up now because it is a tremendous chunk of money to spend when one could put this into the production of personnel who will go out and improve the home care treatment, and so on.

Fourth, they want a computer lab. They really are anxious to be able to program the health data that they are pulling together and improve their computer laboratory capability. That is $36,000.

Satellite hemadialysis unit they want -- they have one five-bed unit presently, operating at Fargo; they want a three-bed unit put together at the United Hospital in Grand Forks, which would give them two in the state.

A project review program for North Dakota certification and need law and the Federal capability expenditures; $25,000. They want to bring in a consulting firm, John, to tell them what the capability of a certification of need law is. You will have to comment on that for us.

They are talking about a human services center, for $41,700.

They have developed a medical park, with two new hospitals going up; I believe it -is in Grand Forks, and they would like to put up a separate facility in which all of the other health and human services agencies are placed, so that everything is placed in one area there, and they can inter-

HD18

digitate more effectively for the coverage of people being serviced by that area.

It sounds like a good idea; they put it on the bottom of their priorities list.

Number 8 is a data analysis -- two of these have been withdrawn. The last one is development and teaching health data collection forms, to be done by the Department of Health in Bismarck; $25,000.

I am very concerned, personally, about the amount of time that is spent up there collecting data and analyzing it. I don't quite understand what they are doing with all this data; they were talking about this back in 1967. It seems to me they should have been able to get some kind of an operational base on what can be done in North Dakota, with all these years of RMP activity, so someone from Staff or Doctor Scherlis will have to fill us in on that.

I would like to suspend further commentary on this at the moment. I can't decide whether or not to suggest that we hold them to the targeted funds, or to wack out the $400,000 entirely, as we just did on that project.

MR. CHAMBLISS: Thank you, Doctor Slater. Mr. -- Doctor Scherlis?

DOCTOR SCHERLIS: I don't know if I can be helpful in this. When I was in North Dakota, I guess I share the concerns that other site visitors have had previously; this

WHD19

has been a state which, at least in my experience, has been rather unresponsive to suggestions from out of state.

I remember as I was leaving, going to the airport, a finger was thrust at my chest and I was told that:

"You people from Washington just don't know what we people out here really need and should do."

And I only resented it because I wasn't from Washington.

Their Executive Director makes this a 25 percent effort as far as his time allotment, and there is no Deputy Director, so that is a blank. And I think this is indicated in a way by the type of projects that we see, because these do not really indicate any homogenous presentation in terms of addressing what many people who come to that state feel the real health needs are.

When I was there the thrust was more toward Physicians' Assistants and Emergency Medical Technicians, on the bais of what has been there described as far as the ratio of physicians to the population of the state, and it concerns me that they are going at the computer approach rather than through the people approach.

Two of the projects have beenwithdrawn, two which were given very unfavorable ratings by their local CHP agency, so this reduced their overall request by, I think $28,000.

DOCTOR SLATER: Both of those were data collection, again.

DOCTOR SCHERLIS: Their staff is small; they have a 25 percent Executive Director, an Assistant Director for Administration -- that's another -- that is a full-time person, and they have two individuals in Program Evaluation, which is a person and a third, and a full-time person in Health Education, who is a nurse involved in health education, so they do suffer from lack of staff, as a great many of these projects appear to derive from the university.

When we were there there were some hopes of having areas outside of the larger population centers, and let's face it -- North Dakota does not have many large population centers by our criteria, but these do not seem to have been implemented, and I think -- and are affected in the present report.

As you look at the individual programs, you can fault them. I think in terms of using RMP funds for residency programs at a medical school, you know, if you can't get your money anywhere else, RMP can be approached, and yet you could say that in North Dakota, if they can attract physicians that come to their state under any guise, this is a wholly worthwhile way of improving health care.

I am impressed with the fact that this has a little different flavor than it used to have; at least they are interested in more ways, in health care delivery, and the North Dakota project, at least in my experience before, was

HD0.21

very much from the top and not totally physician and provider oriented.

I am concerned, as Doctor Slater was, about that biomedical communications system for $400,000, and also into the application of computer technology, which was another $36,000, and this was to have health care professionals in the state -- as they said it:

"...affect an evaluation of the application of computer technology in health care fields."

And the way they would do this would be to have the physicians apparently located in different communities to have access to the computers, in order to improve the delivery of health care, and as I read this, I don't quite know what they say.

The speak of the "selection and implementation of process for computer programs or software will require considerable investigation of computer systems now in operation, and therefore considerable travel, study and collaboration with other investigators throughout the United States will be necessary."

And I guess what they will be looking for are programs that will help physicians improve the level of health care. This is how it comes out, and I would think that, Number 1, the funds that they ask for won't be helpful in that regard, and Number 2, a lot of these programs are readily accessible by getting in touch with other areas and utilizing

the mail, and I wonder how much acceptance there will be by North Dakota physicians in this, and I don't sense from this that the homework has been done.

If you talk about a state that asks for three and a half million dollars, and you cut it down to two and a half million, I don't feel very badly.

But when you take a state that is asking for a relative pittance -- it is already the lowest-funded -- and then you begin carving out big chunks, you leave it with very, very little, if anything, to move on.

So one rational approach that I also should have mentioned in my discussion before is inconsistency, which is again, one of my chief virtues.

So I don't feel constrained to be consistent in any recommendation that I make, and one thing that this Review Comittee has always impressed me with is its great ability to be consistent. This has been, if anything, the most consistent feature about it, including the directions that we get on top, about what RMP means this year, at this meeting and this has been true of every meeting I have ever attended, and I think that I won't have to defend consistency any longer in that regard.

So I would support your general comments; I guess it is a question of coming up with a sum of money to recommend, and perhaps you could have some discussion before we offer

HD23

that motion, if that is within the purview of the reviewer.

MR. THOMPSON: Has there been any Staff input on this $450,000 thing?

MISS RESNIK: Yes, there is one letter in response to a question which I asked a Doctor -- did he need to do all of this at this time? It is tied to the four AHEC's at the four big cities -- Grand Forks, Minor, Bismark and Fargo.

He suggested yes, they probably would not tie in with all of the facilities as originally planned. The letter which I guess I just haven't had a chance to duplicate, is from the project Director, Doctor Christopherson, who suggested that he could reduce the equipment by about $80,000, and manpower by $24,000, leaving a total of a little over $300,000 for the project.

That still is very large, and I believe what may have happened is that they approached the AHEC's and they couldn't get additional funding. They are funded for five years out of the old Manpower grant, and so they are just trying to do something with this, although they are justifying it on the basis of the educational programs in the medical schools.

MR. CHAMBLISS: Doctor Miller?

DOCTOR MILLER: I don't think I have a vested interest, so I think it is all right for me to make some comments.

I have been a big brother to the North Dakota RMP's for a long time, and we really need to understand the Dakotas in the center of the country, in a program like this; you know, the Dakota Territory was a territory and when they finally became a state, which was a long time ago, but it was one of the latter ones, and North and South Dakota are typically pioneer American -- rugged, independent individualists, everybody doing his own thing now in his own way, and to heck with his neighbor, and they never could get together.

They still can't; they are divided between North and South Dakota, as different as though they were arch-enemies, though it has modified somewhat lately.

North Dakota medically of course is very small; the population is 500,000, MInnesota's is one million. They have 50 hospitals in North Dakota, whereas Minnesota has 286.

They have 500 physicians; Minnesota has 5,000. They are arch-conservatives, rural America, independent; they have some justifications for it, incidentally. They have very small amounts of medical personnel and hospitals, by population ratio, but do you know where the longest length of life is in the United States? Northern North Dakota.

They have the fewest number of health care facilities in the United States, by population -- Northern North Dakota.

So maybe there is something about health that is

more important than medical care.

Now, they are beginning to change, and the change is motivated by the very great need for them to have a complete medical school. Nowadays, their two year school, which incidentally was a superb one -- their graduates could choose almost any other medical school they wanted to go to in the United States and get admitted, because they were very, very well-trained two-year men.

But that is not an option now, and they really desperately need to develop their own medical school. They have a big AHEC grant, and have these four units which have the potential of developing a clinical tie-in, multiple small places, with the medical school and still maintain quality in medical education at the clinical level.

Now, they need support in every way they can get it in order to carry out this rather ambitious plan. They also pioneered in the training of medics, and were one of the first ones, along with Duke -- but a different approach, of training Physicians' Assistants, which has gone very well in North Dakota.

So they are moving into a cooperative approach, they are cooperating with each other in their viciously competitive adjacent towns better than they have before, and I would put in a plug for --- let's give them a little push.

DOCTOR CARPENTER: Is it really true that people in

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North Dakota live longer, or does it just seem longer?

(Discussion off the record)

DOCTOR SCHERLIS: Anecdotally, North Dakota is the only place I have ever been to where the home that we went to, which is one of a series of apartments, instead --

(Further discussion off the record)

We do have a number we have arrived at.

MR. CHAMBLISS: All right. We would like to have the recommendation of the presenters.

DOCTOR SCHERLIS: I would not be prepared to defend it, but that is for a number of $500,000, which is midway between, actually, what they have asked and what is targeted, and the rationale that we have used, which is not offered as a means of defense, is that they now have a level of $367,000, they requested $774,000, and actually reducing that by what they have indicated they can, which is $104,000, plus eliminating two projects -- which is not a significant decrease -- it comes to a total of $100,000.

I would think at this particular time, with the medical school coming in, that within the constraints that they have during the coming year, this would be -- I would assume the values of the programs they are looking at, and certainly they can come back in July for more.

The major reduction is what they have indicated they can take.

WHD27

MISS RESNIK: They are not coming back in July, according to their suggestion.

MRS. WYCKOFF: Can they come in now, or is it too late?

DOCTOR SCHERLIS: Well, even if they are not coming back, this reduction, $104,000 -- what they have indicated they can make by dropping two projects, again this is not a significant reduction but I think it reflects on some of their -- well, computer services, that the other additional reductions have made, so this is $500,000, which is over their present level of funding.

DOCTOR SLATER: It effectively takes out the bio-medical program. Since the $360,000 was put into microwave sending and receiving equipment, it makes it possible for them, though, still to spend somewhere between $20,000 and $40,000 to put in four audio-visual learning packages in the AHEC centers, which could be used locally to improve teaching techniques for various types of personnel.

By suggesting this, we have taken $224,000 out of the request, so we have effectively killed off the biomedical system.

MISS RESNIK: Yes, they still have a start, and now we can go ahead, if it is agreeable, to suggesting limiting the locations where they are going to try out this " Medline" microwave.

MR. CHAMBLISS: Would the Committee so recommend? Did we have a motion to that effect, or was that a recommendation? May we have a motion, please?

DOCTOR SLATER: Motion by Doctor Scherlis, seconded by me.

MR. CHAMBLISS: It has been moved and seconded that the level of funding for North Dakota be at the level of $500,000.

Is there discussion?

DOCTOR SLATER: I would like Mr. Thompson to refer briefly to that question before we go on.

MR. THOMPSON: There are 24 states that have certificate of need legislation.

DOCTOR SLATER: To spend $25,000?

DOCTOR VAUN: The importance of certificate of need legislation in a state that is -- that has only two dialysis units escapes me, but what I wanted to make was the observation that the knife seems to be getting sharper as the day wears on, and I am especially sensitive of this when we have been dealing with other Regions whose requests are in the millions.

We have arbitrarily landed on the target figure, and when we are dealing with a small state like this, that has a very small -- $80,000 makes a lot of difference, and in light of Doctor Miller's comments, I really would like to see us

VHD29

give them at least the target figure.

MRS. SALAZAR: Mister Chairman, I endorse that.

Is discussion still in order?

MR. CHAMBLISS: Certainly.

MRS. SALAZAR: I used to have some administrative responsibility for the state of North Dakota, and of all the Regions I have ever dealt with -- and I have dealt with quite a few -- the state of North Dakota has a long history of being very penurious in their applications. They spend money wisely and they spend it well, and they are very fiscal, they are very accountable to every dime.

I am looking down the list of the RAG and I see a lot of old familiar names, and I also see some on the staff, and I also note that they are trying to recruit a Deputy Director, which is one of the things that I recall is an old problem, and I am wondering how much we would damage the program if we reduce it by a relatively small figure? How attractive this would be to somebody they are trying to recruit for leadership, which is very much needed in this area.

DOCTOR SCHERLIS: We would like to withdraw our motion and suggest that it be the targeted figure.

MR. CHAMBLISS: The amount mentioned in the motion is withdrawn and the target figure is substituted, and that figure is $582,217.

WHD30

DOCTOR SCHERLIS: I would also like to just note for the record -- it is interesting to note, and we should have mentioned this in what I think is a very active motion on appeal -- they never ask money for overhead. Isn't this true? They are the only state in the Union that refuses to ask for overhead of RMP, and maybe this is a way of refunding some of that overhead.

MR. CHAMBLISS: Question? Those in favor of the motion?

(Chorus of "Aye")

Those opposed?

(No response)

The "Aye's" have it; the motion carries.

DOCTOR SLATER: Will the Staff advice going back on this indicate the concern over the priorities of communication and so on?

MR. CHAMBLISS: Yes.

MR. THOMPSON: And the certificate of need thing?

MR. CHAMBLISS: And the certificate of need thing.

DOCTOR SLATER: This concern is coming from people who have spent time in the rural areas.

MR. CHAMBLISS: Will the Staff note that?

I would now like to ask the Committee to make a decision as to how we could proceed during the lunch hour here. We have completed the review of eight regions this

morning, we have eight left; we could, if you wish, complete one more and then -- Northlands, and that would free Doctor Carpenter, and then after that immediately start in on Texas, and that would clear Doctor Slater.

I stand open for suggestions from the Committee as to how we should proceed.

MR. THOMPSON: Let's get going on Northlands.

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WHD32

REGIONAL MEDICAL PROGRAM REVIEW

NORTHLANDS REGION

MR. CHAMBLISS: All right, let's move forward to Northlands, and let the record show that Doctor Miller, the former Coordinator of Northlands, has absented himself from the room.

The reviewers here are -- is Doctor Carpenter. Staff support will be provided by Mr. Jewell, on Northlands.

DOCTOR CARPENTER: Well, this is a -- sort of the same problem. The Coordinator, as is perfectly obvious to everyone here, has left, and I think he left quite a hole.

The Region has given up its own priorities, or if it hasn't, at least it doesn't mention them in the application.

The staff is -- it simply lists the Federal words and then says what it might do after that.

The staff is tiny; there are four people, with three professionals. They have in mind enlarging to five, I believe. But I see no evaluation of any significance, and again, the projects don't seem to me to have any specific goals.

They are talking about area health education centers but it is not clear that there is local support for these, and it seems more a question of bringing in Mayo-produced software to be displayed to hospitals and staffs who undoubtedly will be busy elsewhere.

HD33

They don't have any activity in primary care, and I was pretty concerned at that point. That was my first time through, and I -- after I went back through it again, it is a triennial application; this is the third year.

Their mechanism, except for the staff, I guess -- their mechanism is intact. The RAG was inactive for a while, but it seems to be back again.

The man who took over was the Deputy Director for a number of years, and he puts together a very mechanical application. It is beautiful, you know? All the -- everything is color-coded, and you can find your way through it very nicely, but I just don't find any substance there.

The contracts through CHP and the state agencies will apparently lead to the designation of Emergency Room facilities by classification and a better communications system between the various agencies providing emergency care in the state, and this will be something which I believe the original Coordinator started, and it is going to leave a legacy that I suspect will be useful.

The definition of levels of training for various kinds of emergency personnel and performance standards have been elaborated, and for the continuation and development of this emergency project, they are asking for $140,000 for local plans, and $120,000 for the state coordinating mechanism.

Then there is this network of community-based health

WHD34

education centers; they do have local councils, and at least a part-time staff now, in each of the areas.

Continuing education was -- has always been, I guess, of importance to them, and they have continued that. They are -- they have a series of these AHEC's; they have a standard description on each of the projects, which is goals that I think were set sometime ago, and then on some of the projects, there is typed in with a different typewriter some additional ideas.

For instance, some of the -- they have a management training program, and some of the AHEC's, but not all of them, will take advantage of that.

One of them is going to get involved in public education, but no particular information about exactly what that means.

Altogether, this program for the community based health-education centers will cost about $636,000-$640,000.

Then there are -- they are interested in the PSRO, business, and they are not coming at it in a way which I would think -- or, I would think they probably should have not started this way; they are interested in quality evaluation, and they know that they are laying the groundwork for a PSRO, but I am not sure that they are going to -- I am not sure how you look at it.

They are going to set criteria, but they are going

WHD35

to develop nine pilot programs, too. And all in all, they will invest $190,000 in something called the "Foundation for Health Care Evaluation," and I hope --

MR. THOMPSON: It sounds like a PSRO to me.

DOCTOR CARPENTER: I hope we can have some description of what that organization is.

They have managed to pull together some people who don't ordinarily work together in quality care; they got the Medical Society and the hospital group together, and that must have been a challenge, and then they got the Mayo Clinic to go along, too, so there has to be something good going on there.

Well, we have a state -- they want to coordinate a state hypertension control program, and that will cost $133,000 for clinics -- for a clinic in one hospital, and then $87,000 for software for public education programs.

There is $120,000 to sell the idea of organ procurement to both the public and the professionals, and a part of that program is to find out why heptatitis is a problem in transplantation.

There is $69,000 to start the last two CHP's that the state thinks they need.

Some of the projects are so vaguely described that the state A agency expressed concern in regard to two of the projects, involving the specificity of the plans, and I guess,

that I am on CHP's side.

Can we hear particularly from Staff about the nature of that foundation for health care evaluation?

MR. JEWELL: Doctor Carpenter, I questioned Mr. Wilkins when he was in here, on this, and it is a fund-holding company. No, not a fund-holding company; I am trying to think of the words he used.

I really can't answer your question; I could not get a satisfactory answer at the time he was in there, and I did question him on this.

DOCTOR CARPENTER: All right.

The number of that project -- well, it is hard to find the projects because they are under several categories.

MR. CHAMBLISS: Is that 107S?

DOCTOR CARPENTER: We can find it by the dollar value.

MR. CHAMBLISS: 107S and 107? Would that be the activity?

DOCTOR CARPENTER: That is, probably.

MR. JEWELL: That is the hospital association.

(Discussion off the record)

MR. THOMPSON: They say there is $326,676 in quality assurance; how did that number get arrived at by Staff?

DOCTOR CARPENTER: Well, it is hard, I'll tell you.

WHD37

I spent a long time last night trying to do that, but you can add up the various projects in that area.

MR. THOMPSON: Well, there is 17S, which is $158,000; then there is 107, which is another $73,000, so evidently Staff, or whoever made up this briefing sheet, must have combined those projects that had something to do with quality assurance, to come up with the fact that 20 percent of the budget is on quality assurance.

MR. JEWELL: That is from their words, Mr. Thompson. It is on the purple sheet in the front.

MR. THOMPSON: I only got the yellow sheet.

DOCTOR CARPENTER: There is some blurring, too, because there is a hypertension program that was -- well, there are several of them. One of them is a quality assurance program in hypertension.

So some of this quality assurance business, I think, has a little bit of pizzaz to it. There is a guy from the Mayo Clinic who is working pretty hard at it, and he started with a single disease and worked out criteria and applied them, and now wants to expand it to a couple of others.

MR. THOMPSON: Beverly Payne did that a couple of years ago in Michigan. You know, and he started out with more than one disease.

You know, it is awfully difficult; these guys are just rediscovering the wheel.

DOCTOR CARPENTER: It is awfully difficult to match and meet these. He is matching the relationship between the ability to meet the criteria and the outcome, or trying to in a hypertension project.

And I think that -- you know, that is a significant area that requires more innovation.

Let me -- you want a funding level, or do you want to talk a while?

MR. THOMPSON: Go right ahead.

What about the kidney thing? Is that going to be legit?

DOCTOR CARPENTER: I don't think, very; no.

MR. THOMPSON: I'd like to pursue legitimate projects here; I've got 20 percent wrapped up in quality assurance and I'm not sure that is not a PSRO basis.

I have $149,000 or 9 percent of the total budget wrapped up in kidney disease.

Then I have the payoff to CHP, which I'll roll by.

MR. CHAMBLISS: Let me speak to the CHP issue.

MR. THOMPSON: I didn't include the CHP.

DOCTOR CARPENTER: The quality assessment, there is about $190,000 going into what might be a PSRO, and if it is not it is so vaguely described it would be impossible for me to support it.

WHD39

The rest of that $326,000 -- you know, I think it is not unreasonable to suggest something will come of that, and it certainly will not be a complete PSRO; it will be, you know, an opportunity to try to lead people beyond Beverly Payne's criteria, which I believe is terribly important.

The renal project, I don't think, is very good. Are you suggesting though, John, that we are not supposed to fund renal projects at all? And I guess the issue then is this is not a continuation.

MR. VAN WINKLE: That is not a fact.

The only thing we need to do is flag the kidney so it can be discussed with Doctor Goodman in the end-stage renal program. We have to make sure that they are in compliance, and this sort of thing is not something you fund without checking.

DOCTOR CARPENTER: The main thing with that kidney program is that they are talking about procuring organs, and they don't tell you for what.

I assume they don't plan to bank them indefinitely, but I don't know.

MR. VAN WINKLE: Could I speak to that?

Doctor Fred Shapiro is the Director of the Renal Program in Minnesota and probably one of the leading nephrologists in the country in terms of setting up what we consider to be one of the better programs that we have seen.

WHD40

HE does have true regionalization; he has been taking care of the Dakotas, too, as well as Minnesota, and those satellite units you see basically are coming out of Shapiro's units.

DOCTOR CARPENTER: Does he do enough transplants to have an impact on things?

MR. VAN WINKLE: Absolutely.

MR. THOMPSON: I guess my concern is the kind of field you have for the project which is not matched with at least my idea of the resources that are available in the state.

DOCTOR CARPENTER: You mean you think they could do more with what they have?

MR. THOMPSON: I am talking about -- you know, there are some very good people in that state.

DOCTOR CARPENTER: Well, you know, I can't argue with you there.

MR. VAN WINKLE: Mr. Thompson, I don't think there is any question that after Doctor Miller left, most of the other staff left also, and at one time all we had was Mr. Wilkins, his Deputy, and I believe one other person. Is that correct? And one part-time individual, and I -- Mr. Wilkins is excellent; I am not questioning that whatsoever. It is just so thin.

MR. THOMPSON: In the old days, we used to get some

real flaming projects out of there.

MR. VAN WINKLE: That is right. Their RAG and their Executive Board are excellent. They are very good, but they went into -- as I heard someb o dy mention earlier -- into neutral, and they informed us at that time that they were making no moves or any decisions or moving forward in any way until they got some answers from us, and we informed them back: "You may have a considerable wait," because we didn't have any at that time.

So there was a period of time there was very little happening.

DOCTOR CARPENTER: Our idea now, at a $1,250,000; the target is $2,170,000, the request will, by July, amount to $2,500,000, and I would think we might start now at somewhere around $1,600,000.

DOCTOR WHITE: Can I interject a comment?

According to the yellow sheet, at least, all but $226,000 is for on-going activities. They only ask $226,150 for new projects. I don't know what percentage of continuation projects are being augmented, financially, but if you cut them too drastically you may not even allow them to continue what has already been started.

DOCTOR CARPENTER: Well, it is not too clear.

MR. THOMPSON: They may be supporting them, but their annualization funds now --

MR. CHAMBLISS: Did you have a comment on that, Mr. Jewell?

MR. JEWELL: Well, Doctor White, I don't know if it is unusual but it is probably unique. For example, on EMS they will set a limit of perhaps $25,000, which are funded through the CHP B agencies. You don't -- it isn't grab-bag here; they set a fund and if you can comply-- they set a fund for a certain amount, and if you can comply with what they set out as their goals and objectives, then that set amount is all you get.

MR. THOMPSON: I think it is too drastic.

DOCTOR CARPENTER: Do you? All right; I had $1,700,000 -- I was anywhere, all over the map. If you were to say -- well, give them what -- there is no way that those three guys are going to bring home the bacon and a $1,700,000 worth of projects, even if some of them are now under way, I don't think.

But I don't know; what do you want to do? Give them half of their new projects, and what they had before?

DOCTOR WHITE: Does anybody know at what percentage their old projects have been inflated?

MR. CHAMBLISS: Do you have any idea?

MR. JEWELL: It is not a great amount. I am sorry, I don't have that figure, but augmentation of $10,000 would be a lot.

DOCTOR CARPENTER: It has to be augmented in a bunch, doesn't it, because they went from --

MR. JEWELL: Well, I meant on the individual. There are some of them, Doctor Carpenter, that are larger.

DOCTOR CARPENTER: $600,000 increase; their request is $600,000 larger now than what their annualized amount is, and they are reduced in staff, and they have $200,000 worth of new projects, so there must be a $400,000 increase in their continuation -- $300,000 or $400,000 or something like that.

MR. CHAMBLISS: All right. Are you prepared to make a new recommendation, or does your former recommendation hold?

DOCTOR MC PHEDRAN: I have an observation to make that may be beside the point; it is on a matter of detail.

I think that this matter of developing standards for care of common problems in different hospitals and office practices and so forth, that it is to me an argument of no effect that somebody else has done it in the past, Beverly Payne or anybody else.

I really think that people's behavior in the management of these things will never be changed until they are doing it themselves on a local level. I think that it is worthwhile to avoid the duplication of efforts in various parts of the state. I don't think it is an inappropriate expenditure of

WHD44

money.

Now, I don't know whether it is within RMP guidelines; I haven't really gotten that far in thinking about it. But I really think, from what I have seen since I have moved to Augusta, it makes me feel that the efforts which are being made the staff of this community hospital to develop -- they are doing GCAH types of preparation for audit purposes, is probably going to be of more value to us than almost anything else you may have done, and it really did not help them a lot to know that somebody else had made some recommendations in the past.

I know it sounds like God and Motherhood, but I really think it is true; I don't think there is any point in bringing anybody else's recommendation in except as it guides you in making your own.

MR. VAN WINKLE: Well, that is certainly something that can be checked out by staff.

DOCTOR CARPENTER: I don't think if that is the start-up project that that is a problem. It is this non-specific -- whatever it is -- $190,000 for the foundation for health care evaluation, that we just know nothing about. I don't think that is the problem.

The other half of that money is for quality assurance, and I agree with you. I think it is the best thing they are doing, and ought to be supported.

VHD45

So -- would you believe $1,700,000? That is a motion.

DOCTOR VAUN: Seconded.

MR. CHAMBLISS: It is moved and seconded that the level be set for Northlands at $1,700,000.

Is there discussion on the motion?

Those in favor?

(Chorus of "Aye")

Opposed?

(No response)

The motion carries.

The Committee has done all its work assigned for the morning, and I would say we can have lunch and come back and start with Texas.

(Whereupon, at 12:45 P.M., the Committee recessed for luncheon, to 1:30 P.M.)

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MR. CHAMBLISS: May I call the panel to order and indicate that first, I have been in contact with the Chairman of the other panel and they are moving along with speed.

We are looking forward to the joint meeting of the two panels so that we can have a view of what they have been doing and they in turn can see where we stand and we are not at the moment certain as to whether this group can meet either this afternoon or tomorrow. I am more or less inclined to believe that it may be in the morning.

I would then suggest to the reviewers that you may begin to consider amending your plans with that in mind.

I do know that doctor -- let's see, who has to leave today -- Dr. McPhedran.

DR. SLATER: I am sorry, I am irreversibly committed to leave.

MR. CHAMBLISS: Dr. Slater has already indicated previously.

Will you leave today, Mr. Thompson?

MR. THOMPSON: Yes, I have an important meeting to make.

MR. CHAMBLISS: Dr. Vaun?

DR. VAUN: I have an appointment tomorrow afternoon.

MR. CHAMBLISS: I think that will not be a problem.

DR. SCHERLIS: Would it be advisable that we meet

at 8:00 o'clock instead of 8:30?

MR. CHAMBLISS: I will get that to the other parties.

MR. TOOMEY: What is the purpose of the other meeting?

MR. CHAMBLISS: Since we have been split in two groups to coordinate the work of both of them, so that we can have the joint recommendation covering all of the -- all of the funding levels opposed by the two panels known to and enforced by the entire review committee.

DR. McPHEDRAN: Is that something that you need as a pro forma matter?

MR. CHAMBLISS: It is a pro forma thing.

DR. McPHEDRAN: We can't just give you a blank check?

MR. CHAMBLISS: Since Dr. Indicart has said that this should be a quality review, I think whatever semblance we can maintain of making sure that all of the requirements are met for such, I would hope that as many as can stay over would do so.

I would call to your attention also the fact that we have a new Reporter present.

Shall we then begin with a review of the application from Texas and the reviewers --

DR. WHITE: I hope you all will know I am excused.

MR. CHAMBLISS: Mrs. Salazar and Dr. Slater and, for the record, we note that Dr. White has absented himself from the room.

Miss Murphy, Miss Mary Murphy, one of our operations people will be the staff person on this region.

MRS. SALAZAR: At the outset, I must say at the time of the New Mexico deliberations were 19 minutes, so I am making a push for equal time and a little beyond that, I hope you will bear with me. I am eager not to be discriminatory towards sexes. I thought it would be helpful to go into a little more detail because I found the application extremely hard to understand and perhaps some of you have had the same difficulty.

Texas is rounding out its first year of triennium status, funded at $775,832, which covers 14 project activities, a co-staff of 7 professionals, 5 commercial.

This request continued funding for six on going programs and five new areas of health education, health economics and systems demonstration, health manpower, health care quality, and management of major diseases, amounting to $3,239,000.

There is also a staff development component requested in the amount of $287,000. The present director has served his capacity since November 1973. However, he has had RMP experience since 1970, having served as a deputy

director from June 1971 until August of last year when he became acting director.

The remainder of the corps staff has wide experience from 1-1/2 to 4-1/2 years. The total number of staff was reduced from the time of phaseout from 32 to the present 14. And the various disciplines are impressive.

But, I do have some concern about the region's ability to mount the very ambitious program that they now propose without active day to day surveillance and participation by physicians or more immediately related professions.

I have other misgivings about the region's ability to deal with the broad State-wide medical programs as they propose in the application with a delegation of authority and responsibility through the project's contract conditions. Especially since these issues are addressed in the proposed very highly sensible position, access, utilization, organization, manpower and so on.

The regional advisor group and the board of trustees of the Texas RMP, Inc., which is the grantee, appear to have excellent lines of communication. Although it is the same time noted that the executive committee met only once in 1973.

This committee of RAG which I will hereafter refer to as RAG has added two minority members, one of rural and one urban base.

It is interesting to note that although the program committees were only reactivated in early April of this year, meetings are already scheduled in June with only three replacements out of the 70 members requiring space. I think this is a test to the continuing interest in the State and especially in the RAG-RMP affairs.

The RAG has obviously been very participative in the program development which evolved into this present application. It had a special planning committee in November of 1973 and it met subsequently three times to address internal and external health influences and significant legislative thrust.

The RAG is also moved into the direction of strengthening relationships with the health planning agencies and has met with medical agencies as well as other Federal and other related associations. Several of the projects seem to emanate from these sources.

As a result of the joint Arkansas Council, a proposed rate for high new born death rate is under the Texas RMP for joint funding. This is I think a real break-through for Texas in view of the fact that they seem to be responding better to local needs and demands which cross traditional State lines.

With the CHP involvement in the application, there is some very familiar names with longstanding experience in

health planning, are rather obviously alert and informed to the new thrust of Texas RMP.

I notice that Sister Marian Strohmeyer is actively involved. She has been involved in the health planning in the lower Rio Grande Valley, which is one of the depressed and under-served medical areas of the State.

However, the time frame for the preparation and submission of this application imposed very serious limitations in my view on community involvement and review. And to me it at least created a vacuum in the application in order to review the CHP report. It appears planned. It is so planned that it is almost meaningless to me.

There were four letters of endorsement with two to follow and there was some expressed reluctance from local groups to comment on State-wide programs. They felt they didn't have a bearing, that they were not capable of that.

There is also an element of inconsistency in this vacuum. In February of this year, the second annual meeting of health planners of 22 councils of government was sponsored by the Texas RMP. The purpose of this meeting was to solicit assistance in information about successful projects funded by the Texas RMP since 1968. Another such meeting is planned for next month.

I think that perhaps it is time to inquire about present status and cooperative efforts in view of this, as

well as other pending proposals and the RAG reports. That they are under consideration like the Arkansas-Texas joint council.

As to feasibility, the contract approach to these proposals seems to have some advantage of concise language and subject presentation, the goals and objectives are clearly defined, easy to read.

However, the same economies of language do impose specificity and detail. I have no criticism of contracts per se as a mechanism but I have some problems with the personal non-human approach to fulfilling the provisions of the contracts.

There is a quality throughout here of saneness of the language.

It is common to all the projects and it is difficult to determine the inter phases and the -- the network, in other words, of the relationships of one project to the other.

The language is good and it is lofty and it is worthy and it sounds like they can do it. But once again, the impression that these views that you are looking at, all of these throw a thin layer of professional systems who are unquestionably skilled in such presentation and I have trouble with the understanding of it. I have trouble with understanding the programs commitment to address themselves to these

problems. They don't come through in these little descriptions of the request for contracts. That is my own bias.

There is an intangibility about it that I find is very difficult to deal with. Let me just quote one little paragraph. Description of one of the programs.

To develop and demonstrate educational approaches for barriers to health care.

So much of the contracts and the effectiveness of the contracts, I believe depends on the language, that I find it impossible to get an understanding from what I read in this application of what Texas is going to do with these contracts. I have some concerns about giving contracts to profit organizations and who will monitor them and I will spell those out later.

I would not at this time like to make a recommendation until we hear from Dr. Slater about that.

MR. CHAMBLISS: Thank you, Mrs. Salazar.

Dr. Slater?

DR. SLATER: I thought you were going to be going for 19 minutes?

I would like to say, Mrs. Salazar and I met just briefly at lunch, is the first time we communicated on Texas. And I will simply reiterate for you what my statement was for her.

I was deeply impressed with the objectives as she has quoted them of the Texas program and felt that as long as looking at health education, quality State-wide disease projects, health manpower concerns, that clearly there is plenty of room to move.

And that one cannot fault under any circumstances this kind of -- the set of objectives.

What I simply cannot get a handle on, reading Texas, was what was really coming out of it and I came prepared to say that I am impressed with the range of activities that are going on and feel that, from what I read, that they apparently do have very good review by an involvement of the comprehensive planning group. But I still could not understand it because there is too much, there is too broad a range of activity explained into few words, which I believe you say lack any color whatsoever.

I think that perhaps Mrs. Salazar put a figure on it by saying there doesn't seem to be any medical professional input into this that gives the sense of the priority within the framework of the humanity aspect of it and I am not saying that that comes through that strongly in the other proposals but this is a little too perfect in some ways.

What I am saying is that I am impressed with what they are attempting to do and if one takes a look at page 24, the project status report, contract No. 73-1, continuing

education for registered nurses providing community health services, is on schedule.

Comments: Extended 60 days for additional effort. Progress excellent.

That is fine.

And there is two pages of this type, or 2-1/2 pages of this activity and we simply have to accept the fact that everything except the two projects is on target and doing well.

On the basis of that, there is a request for continued activity of, I can't get here, I would say something like, maybe $300,000, $400,000 extension.

Now, when one goes beyond that one gets into the matter of what do they plan to do in the future?

As Mrs. Salazar pointed out, because they are in a tight time frame, they have decided to follow the general guidelines of their thrust, their objectives and sent out proposals for, send out requests for proposals.

Do you want me to go on with this?

Mrs. Salazar. Yes.

DR. SLATER: And let me, if I can find my way in again, let me give some sense of what they are doing here.

They have an access committee of their RAG, oriented, an access committee concerned about getting into the health program. It is asking for $286,400 for what is

called the Texas health education project. Within that there are a whole series of objectives which are fine. Objective 1 is develop and demonstrate a coordinated approach to individual health education in a selected area.

Then there are Work Activity A. Apply those guidelines developed in RMPT Contract No. 74-14 through a coordinated approach to individual health education in a specific community, town, county, multi-county region. $45,000 is available for that.

Two, determine health education requirements and develop effective means of meeting those needs.

There are four work activity suggestions here sent out, widely distributed throughout the State. They range from Work Activity A, analyze cultural barriers to adequate health care and develop methods for overcoming the barriers through education at $48,000; Work Activity B, develop an outline form that can be used in rural poor communities to assess health status and informational needs at $40,000.

Work Activity C, study the legal barriers to health care as perceived by the consumer and provider and recommend educational approaches to overcoming those barriers at $63,400.

And Work Activity D, demonstrate and evaluate the use of upper division nursing and medical students as remote

area community health educators during non-school periods at $35,000.

Objective 3 is improve health care and reduce overall cost through education.

Work Activity A, analyze areas of greatest consumer abuse in the health care system and suggest educational programs aimed at overcoming same at $55,000.

All of those activities add up to something like $286,400.

Then, under the general rule book of the utilization community, the Texas Health Economics and Systems Demonstration Project are indicated. That is a figure of $636,340, and I think I would lose you if I read over all the objectives and work activities.

Needless to say --

MR. THOMPSON: That is a five-year project conservatively speaking. I just reviewed it just for you, Bob.

DR. SLATER: Thank you. I didn't even speak to you about it.

Health Manpower Committee of the RAG is to assist, coordinate and cooperate with those who wish to perpetuate, expand and improve the quality and output of health manpower in Texas for $160,000, and a very laudable group of objectives laid out here. I don't think anyone is finding any fault

with this.

The report on current distribution and trends in Texas is -- work activity, none is required at this time. They were satisfied at a -- excuse me, that appears to be in here under what they were going to fund and I have been misled.

But they have a series of objectives under attempting to define better health manpower. Here is a very specific one.

Encourage the development of a responsive and timely State-wide health manpower data base for use by health educators, policy-makers and others.

Work Activity A, a six-month study for this purpose, with Governor's Office of Information Services, is nearing mid-point. This is already under way.

(2) Continuing Education Committee is wanting to identify, encourage and assist those health care professionals interested in finding new and more effective methods for providing continuing education in the region, and they require $308,700 for that.

MRS. WYCKOFF: Is that PSRO?

DR. SLATER: I don't think so.

MR. THOMPSON: There is a quality that is laying the base for that.

DR. SLATER: Can you identify that?

MR. THOMPSON: Project No. 111. You mention PSRO specifically in the project, but although it doesn't make it directly --

DR. SLATER: Objective 1 is assist in the development of new approaches to upgrading quality health care in response to identified needs of the professional community.

Work Activity A, establish a quality review task group comprised of physicians and other health professionals to provide leadership and decision-making functions for the project.

Work Activity B, select a technically qualified, unbiased organization capable of providing research, analysis, evaluation and other work support to the task group.

The analysis evaluation, in other words.

MR. THOMPSON: I was on the PSRO task force and I can take this and lay it out and say to the PSRO, here you are, go.

DR. SLATER: The final one is just for $6500 -- I don't think I dropped a zero -- I did, $65,000, excuse me, regional disease management program.

That is oriented to the management of major categorical disease awareness and treatment program in Texas. And the goal is to design and test effective mechanisms for developing and managing State-wide disease programs.

Now, they have several objectives.

To document the methodology in Texas for a coordinated State-wide response to major disease awareness and treatment programs.

Work Activity A, to evaluate the major disease programs supported by RMPT since 1960, heart, cancer, stroke, hypertension, renal, to identify successful and unsuccessful features.

Now, that is evaluating the major disease programs supported by RMP since 1960. That is a lot of work.

Develop a methodology for a comprehensive, coordinated State-wide approach to major disease programs. That is to be sublet to somebody or maybe multiple people for $65,000. There are some other objectives here.

Monitor the major disease programs currently being funded through RMPT.

Objective 3, recommend to the regional advisory group concerning the efficiency of participating, or continuing to participate, in major disease programs.

I am saying that I support this type of activity. I think it is very necessary and we have to move increasingly to it in this country.

What I don't get a feel for, either from this brief description as it appears here or of the more extensive write-ups that appear in the book and they are not that much

more extensive, they are simply almost the same thing laid out on the dollar street activities, required pages required by RMP. I can't get a feel how long it takes to do these. Whether there are groups in Texas to do them and what is the quality of the work that is going to be done. I can't seem to get a professional sense of this.

I am concerned that they are asking for a great deal to be done in a very short period of time.

Now, I gather against this background that they expect many, many proposals to come in and in fact having something in the range of 90 or 100 from which they wish to choose about 25, and I am anticipating obviously that their staff and RAG group are going to screen out those that are technically capable of being done in one year.

I come back to the concerns that Mrs. Salazar had, which I believe should be reviewed here and that is the matter of what kind of assurance do we have of the monitoring that can be done by essentially nonprofessionals, non-physician professional staff and it may be that they need other kinds of professionals on activities that are essentially contracts.

The question I have is when one puts contracts out, are they all to profit-making organizations?

Does the contract carry any concern for the conflict of interest between those who are on a profit-making

basis in providing the kinds that we want in compared to the usual grant system?

I think that -- I don't want to go any further at this point.

Do you have any follow up?

MRS. SALAZAR: No, except for this letter.

MR. CHAMBLISS: Yes, let me introduce the letter.

There has come to the attention of Dr. Pahl what is marked as an urgent piece of correspondence from Texas. It arrived during the break and the reviewers have had a chance to read it.

I would simply submit that the panel may wish to know of its contents.

DR. SLATER: Yes, I think the Texas people were concerned that they had put a proposal into us in which they were really asking us to take on faith the fact that they were going, following the program thrust that you have described and had submitted a request for proposals to be submitted to them and that these proposals are now just coming in and that they are planning to have their RAG staff group act finally on those proposals on June 28 or something like that, which is something more than a month after we would have funded them to do it.

So that we are in fact funding them in advance of the time that they actually make a decision for the proposals.

What they are suggesting is that their proposal as submitted to us, be modified to the extent that they take their 25 top priority proposals and submit them to the RMP staff here who would review them and make a decision on whether or not these satisfy, in essence, the goals of RMP and the thinking of this Committee is the staff could interpret that.

Is that a fair display of what they say?

MR. POSTA: Yes, sir.

DR. SLATER: They are concerned that --

DR. SCHERLIS: Could you translate that?

MR. POSTA: What their picture is, that by going the contract route they would like to have as long a period as possible, meaning 12 months.

If they had to wait until July 1 to get their 15's and 16's in more specificity, by the time it got through all counsel, they would have a maximum 10 months to do the activities proposed and their whole concern is, on the contracts that they had funded in the past, through their evaluation process according to Texas representatives, the ones that have been funded in the least amount of time, have not been as successful as those that were given a full year's duration.

MR. THOMPSON: Do we have any idea to whom these contracts are going to be let?

MR. CHAMBLISS: Miss Murphy, can you comment on that?

MISS MURPHY: I think in the primary and secondary review, a summary of contracts funded from 1972 through 1974, and just reading down to the people that they were contracted to:

Texas Hospital Association -- these are the past ones and probably some of these same will be included in this round.

Texas Hospital Association.

Texas Medical Foundation.

Chamber of Commerce, Tyler.

Coordinating Board, Texas College and University System, Austin.

Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation-Temple.

Human Resources Development Foundation-Houston.

Bexar County Medical Foundation-San Antonio.

Cameron County Board of Health-Harlingen.

Texas Hospital Association, Austin.

Texas State Department of Health, Austin.

St. Paul Hospital-Dallas.

Texas Medical Foundation, Austin.

The University of Texas Health Science Center at San Antonio.

Southwest Research Institute, San Antonio.

And I could go on.

I have another page and a half. Those are the types of people that they were contracted to. They sent them to a very select group.

I have the sheets where they are checked off, how they had selected them and according to their expertise. Five hundred.

MR. THOMPSON: I am concerned myself, only fairly knowledgeable in the area of health care economics, that this project that they have laid out here is very well done, but the problem is that work, the way it is laid out, work activity A has to be completed before work activity B can be begun and C.

When I said it would take five years, I was being slightly facetious. It would take three years.

But, I don't know where they are going to find the people down in the hospital association, because I know the people down there who are going to be able to do this. This is a fantastic -- it is a well laid out, fantastic idea.

MISS MURPHY: They are only going to let 30 to 35 contracts out of this whole group.

DR. SLATER: I assume they are going to operate in the future on the basis as they operated in the past. If one takes project status reports and accepts their very brief

indication of how they are proceeding, one says they are satisfactory, I just don't have a feeling for this and all we can do is assume on how they are going to operate in the future as they have in the past.

MRS. SALAZAR: They seem to be convinced that the contract mechanism is the way they are going.

MISS MURPHY: That is the only way they feel they can go.

MRS. SALAZAR: They feel that their experience with the contract is very good.

DR. SLATER: I will accept that.

MR. VAN WINKLE: They have 130 letters of intent out.

DR. CARPENTER: Did the regional advisory group approve this?

MISS MURPHY: Yes.

DR. SLATER: I think it is difficult to have done more than this, because of the reporting that will be necessary to get a grasp of the reports. Either that or they might have been able to give us an appendix of their status reports which would give us some indication of what was coming out of the projects that are already funded and the implications.

MISS MURPHY: This is what the form I referred to do -- summary of contracts funded. Very small print.

MR. CHAMBLISS: There have been some concerns on the part of staff expressed about the 16's and the fact that they have not gone into any detail.

We would certainly want the views of the committee on that aspect of the application.

MRS. WYCKOFF: Does this mean that they are going to reach out beyond the walls of the great elite establishment in Texas and try to get into the uncovered areas that really been touched?

MR. THOMPSON: These are the same old boys. These are the same old boys.

DR. SLATER: I would like to take exception to Mr. Thompson.

They really are making an effort to look at the mortality rate in the area.

MRS. WYCKOFF: I think the physicians are really on the job.

MRS. SALAZAR: It is very difficult to say, Mrs. Wyckoff, from the reading, the kind of thing Dr. Slater has indicated, it is very difficult from the reading.

This is why I have problems with the application being completed that it will indeed begin to cover these areas.

Mary, maybe you can tell us at the time of phase-out, where did Texas go? How far down the road did it go

back?

Maybe I can get some meaning from it.

MISS MURPHY: They went from 35 people and now they have 7 professionals, 8-1/2 --

MRS. SALAZAR: I am not speaking so much of staff.

MISS MURPHY: They closed all of the sub-regional offices. No more sub-regional offices.

Like these RMP's were sent to El Paso, so many of their old staff that they had, that they knew were distributed throughout the State to try to get a good coverage --

MR. THOMPSON: I don't think seven people can monitor these.

MISS MURPHY: Say that you pick a good project director, why would some person have to go out and do it?

MRS. SALAZAR: How can you monitor yourself?

DR. SLATER: I think what needs to be clarified is whether or not there is functionally any difference between a contract and the traditional form of grant mechanism that the RMP follows in the sense of professional quality and monitoring and judgments that are made.

I think if the committee can satisfy itself, that contracting is just as good functionally.

MR. VAN WINKLE: Dr. Miller has had some experience with that methodology.

MR. THOMPSON: Before you go, because you are going

to have a lot more to say about this than I, when we had a project we had a man, an identifiable person who we sometimes were disappointed but we knew his background, we knew what he was good at and bad at and we could judge the contract, I mean the project. The contract, we don't have the man.

DR. MILLER: It depends on how you do it. It depends on how you do it and my experience with it was essentially halfway between what you traditionally think of as a contract and what we traditionally think of as a project.

And by that mechanism, why you know not only the man but you know the institution, you know what you want them to do and you have a lot better control over it than you have over a project. All the way around.

MR. THOMPSON: It takes a good monitoring system to get that.

DR. MILLER: It takes a good system, yes. But it is not an open-bidded contract kind of a thing. You don't just publish it and give it to the lowest bidder without regard to who it is. You can do --

DR. SLATER: They are not going to do that here. They are obviously going to look for quality projects or work and then contracts.

So would you agree to that in terms of what I understand the system here to be, they are simply using the contract method to finance?

DR. MILLER: It hasn't any positive attributes. I am thoroughly sold on the contract approach to project. It really puts you in the driver's seat with regard to management.

MRS. SALAZAR: Why did Texas elect to go this route?

MR. CHAMBLISS: That had to do with the change of organizational structure.

Will you clear that up, Mike?

MR. POSTA: I guess it was December of '72. Up to that time the Texas system was the grantee agency which was composed of 17 educational institutions. Then they broke away and formed a name and a board of directors and of course by that time we had gotten word that February '73, that we were going out of business.

So the regional advisory group got together and said, if we are thinking about feasibility, short-term pay-offs, we had better think in terms of a period of a year. Their whole administrative mechanism was to build a device whereby they could call the shots, set up the instructions for the contracts, choose the people and pay them for the job done and they, quoting verbally, "have felt that they have done a better job especially in short runs."

They probably would not agree if they had a three-year funding period. But I think their whole premise is based

on that approach.

DR. CARPENTER: Did they use the contract mechanism to get the grants written?

MRS. WYCKOFF: You mean the RMP?

MR. THOMPSON: I think I know who wrote some of these grants. I think that is a facetious question.

DR. SLATER: Well, I think again, given the material that we have in front of us coming from a program that has been site visited and has been a part of the endeavor here for years and for which many people have personal knowledge of the individuals, one has to give the benefit of the doubt.

I think there is another major question that comes up and that is whether or not we feel it is appropriate to consider allocating all or some of the monies for the new projects which have been requested prior to the time that those projects have been chosen. They have requested that they do this with the proviso that we, appropriate the staff here, the responsibility of reviewing those 25, and representing us and the advisory council, that it is appropriate for them to proceed to carry out.

MR. VAN WINKLE: I believe I am correct. Larry, they cannot spend any money until you have 15's or 16's, is that correct?

DR. CARPENTER: What is the 15 and 16?

(3)

MR. VAN WINKLE: The budget forms.

DR. SLATER: They won't be able to start until July 10. As soon as you clear the air and the money will be in the bag.

Otherwise, they won't get through until the Advisory Council meets in August, which is too short and will --

MR. THOMPSON: Are they talking about this or the next one coming down the pike?

MISS MURPHY: They are sending nothing else in. Otherwise the contract will have to be approved and met in July.

DR. SLATER: To get something done.

MR. THOMPSON: We are examining this one right now; is that right?

DR. SLATER: That is right. We don't know what the 25 projects are going to be.

All we know, are the guidelines being used by applicants who already submitted 130 proposals?

MR. THOMPSON: If they can do it, why can't everybody else do it and we don't meet in July?

DR. SLATER: Well, I think --

DR. MILLER: Isn't this a slush fund? That is what we turned down yesterday.

MR. CHAMBLISS: We need the judgment of the

reviewers here.

I would say there is a fundamental issue here and that is, I think Dr. Pahl would be very much concerned here and so will the Council, and that is the local decision-making process has not had a chance to work its will on what you are being asked to make a recommendation on today.

MRS. WYCKOFF: It is a blanket request.

MR. CHAMBLISS: I would -- I wanted to, wanted the discussion to go forward as it has, so that we would thread out of here some advice for counsel and for Dr. Pahl.

MISS MURPHY: Could I ask something?

MR. CHAMBLISS: Yes.

MISS MURPHY: Each one of these proposals as they are being worked out before they are submitted to the RMP, are to be brought to the attention of the CHP. A comment is going to be made prior to coming to the RMP.

MRS. WYCKOFF: Did they make the comments on the RMP that went out? Or on what companies?

MISS MURPHY: They have companies on all of this.

DR. SLATER: I think if the usual history of all the other projects were being followed by this one, we would have 25 more clearly identified, very briefly described projects which we would look at and we would say, yes, that is what they are going to do next year and they only requested

7 percent of the funds that are targeted for them and it sounds good because they have been producing in the past and so let us go ahead with it.

I think that is what we are likely to say as we pick holes in the targets.

MR. THOMPSON: We would have some evidence that CHP --

MISS MURPHY: You will have it. They will have reviewed them before they get to the RMP.

The proposal is, you know, that is the direction.

MR. THOMPSON: What is to stop it even if they get an unfavorable review?

DR. SLATER: I think what they have done is wire us and put us on the record and said that the 25 projects that they send up here would only come on the basis that they went through the usual process and then they put this staff in the position -- put us in the position of depending on the staff to legally or to put their names on, agreeing that these are appropriate.

MR. THOMPSON: This is going to come up in South Carolina. The same kinds of business, although not so blatant.

I just have a vague feeling that I am getting had.

DR. SCHERLIS: The question is, for how much.

DR. CARPENTER: There are certain things which I will not put.

DR. MILLER: You have been getting had all day.

MR. CHAMBLISS: I would assume those comments are off the record?

DR. SCHERLIS: No, sir, I would like those to be on the record.

MR. CHAMBLISS: All right.

DR. SLATER: I think it clearly breaks all precedent, the past, as well as good operations, to approve this kind of thing without some committee review inputs.

Mrs. Salazar's question is whether or not it would be sensible in this case to have a site visit by some of the review committee and the staff to take a look at the situation here in view of the -- in view of the problem.

MR. CHAMBLISS: I would recognize Dr. Scherlis first.

DR. SCHERLIS: You are obviously looking for some way out. Perhaps we could give a tentative approval, giving their approval by July 1.

I for one, although I know that a great deal of what we are doing at this session is really looking at inadequately submitted proposals and making what in time may be inadequate decisions, I still think we should go through the opportunity that I think we must have and that is exercis-

ing our right of approval or disapproval and not telling the region, you can do what you want on any basis that you choose to and I for one am not that overly impressed that any region, including Texas, once it receives this sum of money will decide that it is going to do anything more, is minimally necessary to have the project operate.

Now, my faith may be less than others because over the years that I have been had, including site distances and I would suggest that we have tentative approval but only contingent that we have approval in July to review the contracts. I offer that as a contract.

DR. MILLER: This contract is a bit of semantics as a sort of semantics. It is trying to get approval for slush fund projects without approving the project. By calling them contracts.

So I support what you do, that we not fund it now but give them the opportunity to come in with their proposals in July for how many ever contracts, projects, whatever they wish to call them, as long as they are submitted in the usual way.

DR. SLATER: I don't understand what has happened here. I thought you said you would find it provisional upon the receipt?

DR. SCHERLIS: I offered potential ways of trying to meet this.

I think we need more suggestion on this. I most strongly do not support the concept of giving them funds at this time for what they have asked for and I am trying to seek a way out.

Any suggestion as a way out --

DR. SLATER: The question at this point is whether we will guarantee some sum of money up to what they requested that will be held in escrow here until our requirements are satisfied, which is their submission of whatever the proposal they want as a result of these requests that have gone out and the ratification of those proposals by the staff and now we are adding to that, either a site visit or some members of this committee to get these proposals and talk on the conference, call or come to Washington and do so.

Such things that keep our process intact. If we do that by July 10, we will avoid another whole review cycle which they want to avoid in order to be able to do the work.

MR. THOMPSON: One of the beautiful things about a contract, you can specify time. Therefore if it is 10 months or 12 months, they let the contracts. What is the difference?

DR. SLATER: Because the only way we can do it is to bring it back for the next review cycle and it will be later part of August, and it will add two months.

MRS. WYCKOFF: They add it to the other end?

MISS MURPHY: No, they can't.

MR. THOMPSON: They change the contract and --

MR. CHAMBLISS: We have known for some time that this application presented something of a dilemma. I have just talked with Dr. Pahl on the point.

Dr. Pahl, would you care to make an expression as it relates to -- the contract activities coming in about the 20th of June after this committee --

MISS MURPHY: No, the 28th. The RAG are going to meet and approve them and he said they would be in here by the 10th complete. The 30th of July.

MR. CHAMBLISS: Of July, that is worse.

DR. PAHL: I really feel -- I don't need the microphone -- I really feel that we prefer a definite decision not based on staff capability early July for the following reasons:

Normally I think we would be happy to accommodate that kind of recommendation but we are laboring under some difficulties internally, namely as soon as legislation is passed and none of us know when that is going to be, the department is then going to make its decision as to just how many of our staff are going to be departing on the decentralization basis and I am not sure who is going to be here in July to do the work, very frankly.

I think that it is rather clear issue in the

sense that Texas has had and does have as much of a lifetime as any other RMP. It happens to be a free-standing organization, it is not the only one that we have.

I think that they have chosen to go a certain route and that is their choice, but the other RMP's have been under the same time limitations and are under the same time limitations and I would suggest that you not treat them special than from the other RMP's.

If you can find it appropriate to arrive at a decision on the basis of the information provided, which leaves you comfortable, we will take that recommendation to Council.

But I do not prefer to have it come back to Committee -- the staff, because I really don't know our capability to manage this responsibility and it would be really a disservice.

The other thing is: I am and you should know this, working with the Office of the Administrator to try to get an agency policy statement developed which will be sent to grantees pointing out what the Federal responsibility is for monitoring activities which go beyond the lifetime of RMP's, just trying to look to this eventuality and Dr. Margolis is very sympathetic.

We have drafted a statement and if this were to occur, for example, then some of the time pressure would be

off of free-standing organizations. You have to realize that the Government always has programs terminating and continuing activities within those programs.

All I am trying to do is to formalize a Federal responsibility at an agency level which would assure Texas and its affiliates, as well as all other grantees, that should another monitoring device beyond the RMP be necessary, perhaps it could be this agency or the regional offices that could assume that responsibility.

If that were the case, then the fact that an activity got started later, that would not be so detrimental. Because that is the thrust of Dr. Ferguson's point of view.

In essence, I don't believe that we can accept those kinds of workloads projected into the future with what I know to be our own situation. I feel Texas has a right to choose its method of handling its funds and grant application.

I do not believe that it is in any other position than any other RMP or will be treated differently.

To that extent then, we leave you to your own considerations. But perhaps it does give you some guidelines.

MR. CHAMBLISS: Thank you.

Dr. Vaun?

DR. VAUN: I think we are playing semantics here. It is unfortunate that Texas picked the word

"contracts." I think we awarded slush funds in the last day and a half and I don't see any reason why, because they selected the word "contracts," that we should treat them any differently.

We talked about slush funds up to $800,000 up to this point, with very ill definition of what was going to happen to that money, besides it was being tucked away for future legislative proposals.

DR. SLATER: May I make a motion to get something on the floor and that is that we, I find it possible to make any decision on how to cut back on what they suggested, so I make the motion that we fund them to the amount that they requested and that --

MR. THOMPSON: After all this, you are going to do that?

DR. MILLER: Go ahead.

DR. SLATER: Subject to the contingency that the proposals that they submit are reviewed by a technical -- by the staff and by a technical site visit.

I think the point is, I don't think that we can bypass this committee if the committee will have to give the responsibility to some members of the committee and staff to go to Texas and it is just one day, to get a grasp on this, to see if we are fulfilling our Federal mandates.

I don't see this as a slush fund for Texas projects.

I think that the technique used has just been delayed bringing projects to look at.

MR. VAN WINKLE: Who would the site visitors report back to, doctor? This group or Council or to whom?

DR. SLATER: Back to this group who will be sitting here in July.

MR. CHAMBLISS: I think Dr. Pahl has, if I may make the point, has stated that we are uncertain as to the status of our staffing after the first of July and we have no indication as to what our staff availabilities will be to help decide this question.

DR. SLATER: You have another round of -- you have another review cycle to handle.

MISS MURPHY: July and August.

MR. VAN WINKLE: Another group has laid on us that visit here, right?

DR. PAHL: I think there is a different question than what I heard coming up before.

We do have a July meeting of this committee, an early August Council meeting.

If what you are doing is recommending approval subject to your reconsideration in July and then notification of the region and if the Council would buy that, they would thereby in reality have a mid-July approval from you for the full amount.

DR. SLATER: We met here on July 18, which is one week after they are going to submit it.

DR. PAHL: That gives them three weeks.

I understood you to say that staff to do it July 20. You may recommend approval with -- contingent upon it coming back and confirming it at the July meeting but basically that does not give the money to Texas and they can't go ahead and spend it until July 20 or thereabouts which is three weeks different than if they take more time to describe it in their July 1 application.

I don't know whether that is a good thing or not.

DR. SLATER: Is it technically possible for this to be approved by the Council and not have to go back to the Advisory Council?

Could they give this review committee final right of approval?

MR. THOMPSON: If we make that recommendation.

DR. PAHL: We would take that recommendation to the Council. If they accept it, then we could implement it.

DR. CARPENTER: It seems to me that we can accomplish the same thing in a much more standard way. I suppose that if we are right, that these people do have the opportunity to develop a good selection of projects, and we want to get them started on that, we can approve an amount

of money now.

For instance, we would want to support their corps staff right away. We could support something around $1 million which would get them well past July and if they have the confidence that their program is reasonable, they can assume that when we have a complete description in July we will approve such additional funds as will be necessary to carry out the program.

I think what we have is a region that is now operating $348,000 worth of projects, a very small number of projects.

They are saying that within a year they can productively spend nearly $1.5 million on new projects.

I think that I will require additional convincing. So, I think that you get them started and they have plenty of money to go on, until we have a chance to see their detailed proposal.

MR. THOMPSON: May I ask a question, because I am confused at this point.

This damn telegram that keeps zipping in, we should have taken it up this morning.

We are talking about 25 additional projects, is that correct?

DR. SLATER: No.

MR. THOMPSON: You are talking about these?

DR. SLATER: They requested the program staff money and then they have also requested in this package, money to continue and complete that which is already under way. Something like $348,000 there and then they said we need about $1.5 million for new studies but we haven't got the projects yet. We have the areas and we put out to bid but we don't have the project yet because we haven't had enough time to get them in.

We would like you to give us the right to spend up to $1.5 million which is what the budget boils down to, to support these contracts when we, when our RAG has received them and decided what are the high priority ones and by some mechanism this review committee likewise approve them.

We are simply being asked to approve in advance what they are behind in. I don't see it as a slush fund because it has to be reviewed by their RAG and reviewed by us in some way.

MR. THOMPSON: Let us just take this crazy, damned economics of the whole delivery system. $656,000 --

DR. SLATER: Those are guidelines for proposals. Those are not the projects. you haven't seen a project description there. You have seen guidelines for proposal.

MR. THOMPSON: O.K. Then I understand I buy Dr. Pahl's proposal that we request Council to permit us at our next meeting to review some of these contracts.

DR. SLATER: O.K.

DR. CARPENTER: They haven't even chosen sites for these projects.

You look at the site selection sheet, they are blank.

DR. SLATER: Because they have come in. The whole reason to come in now instead of the next route is based on their argument that they have one year left like everybody else in the program and they haven't asked this question about any other projects.

They said, we really need a whole area if we are going to contract and try to do what we are doing. So, we would like to give you a new advance.

MR. VAN WINKLE: Dr. Pahl indicated that three months from now or four months from now, contracts for a full 12-month period.

It is just that the end product will be monitored by somebody else. They can let a contract.

DR. SLATER: They can do it up to the last minute as far as the monies are spent.

MR. THOMPSON: Why can't we separate the thing out? Give them a certain amount of money, writing RMP's and then request counsel to permit this Committee to review the hard proposal at the next meeting and approve or disapprove them without going through Council.

DR. SLATER: That sounds like a good idea.

I just had a question strike me like a bolt of lightning.

This is the first time it has happened. Who is going to monitor any of these things?

All of this work that we are farming out, Dr. Pahl, who is going to be looking at the reports that are coming in?

DR. PAHL: That is what I was alluding to.

MR. THOMPSON: We brought this up yesterday, about what is the --

DR. PAHL: In practical terms, it may not be as bad as it always appears to be.

For example, the chronic disease control program disappeared, but I remember RMP for about 3-1/2 years matching contracts as a result of the Federal commitments. The whole kidney activity that we have been doing, is the fold-over and so forth of that activity.

I sat with Dr. Margolis about -- well, a week or more ago and again pointed out to him that it would seem nice if we could get this agency kind of policy statement which could be sent to all grantees and we now have drafted one at his request which will be looked at every carefully and I am not sure what will eventually happen to it.

But it would be nice if we could tell grantees

that we recognize the program and that there are continuing operations and that the Federal Government, hopefully this agency or regional offices, will monitor and that we won't all have to get out contracts again. I can't make the commitment. We are trying. That is not a problem. It will happen.

DR. SLATER: We can pass this over to the next review cycle.

There is only one problem. When they are operating by contracts, they withhold a certain percentage, I think 20 percent of the funds until the contract is completed and then they make the final payment. If they start late on a one-year contract, then we are past the fiscal year ending and they will have to pay out the funds for the remainder of the contracts before the contract is completed and thereby lose whatever leverage they have on the contract.

MR. THOMPSON: Why don't we just hold the thing? Why don't we just buy --

MRS. WYCKOFF: Put it in escrow.

DR. SLATER: I would like to hear from Mrs. Salazar, Mr. Chairman.

MRS. SALAZAR: I don't feel that that is a real factor in that the Texas RMP has a board of trustees, so I assume that will have some fiscal responsibility to hold these people accountable; am I correct in that?

MR. POSTA: Yes, but at the present time they plan to terminate it.

DR. PAHL: You are in the never, never land of grants, Federal legislation, and there is no one in this room who can honestly state what will happen next June 30 and there are a lot of people concerned and working and nobody in this agency can tell you and I really say that in all seriousness, because we lived with this whole activity, this is the same set of discussions we had internally last year when the program was going to end, Jerry Gardell, Larry Parker and others have been concerned about it a year ago and we are in the same position this year and somehow RMP's are here and as a Federal manager, I am trying my best to smooth the way to get a transition but I can't get a commitment.

I would say, make your decision on the merits of the case and don't worry about the tail end payments of contracts. Somehow it will work out.

Do what you think is appropriate for spending the money effectively in Texas on the basis of the information you have. And you have to arrive at that decision. But we will worry about the continuation.

JR(4)fls

DR. MILLER: I submit, in antagonism, I guess, against the motion, that it isn't going to make that much difference with these activities, whether they start the 20th of July or when does the council meet after?

DR. PAHL: 9th of August. Awards would go out effective September 1.

DR. MILLER: It isn't going to make that much difference, and I fail to see a reason why we should make a special procedure for Texas. Even though, I know they are accustomed to such treatment.

DR. SCHERLIS: What was the motion you made an hour ago?

MR. CHAMBLISS: Was that a motion?

DR. CARPENTER: A motion with a second on the floor.

DR. SLATER: I will withdraw my motion.

MR. CHAMBLISS: The motion is withdrawn and the chair will entertain a new motion.

DR. CARPENTER: What I was suggesting is that what I move, is that we fund Texas whatever the sum of $319 and program existing, plus the continuation project, $348,000, plus another $350,000 to give them wiggle room.

So that is $700 -- $1,100,000.

MRS. WEIKOFF: I second the motion.

MR. CHAMBLISS: It has been moved and seconded that Texas be funded for this round at the level of $1,100,000.

Are you ready?

Is there discussion?

MRS. SALIZAR: Yes, does your motion, Dr. Carpenter, include the rest of your first condition?

DR. CARPENTER: No condition, and I hope they will be back in July --

DR. SLATER: We have another cycle to consider.

MRS. WEIKOFF: Let them come back in July.

MR. CHAMBLISS: With the provision that they will come back in July with a clearer application.

DR. CARPENTER: No provision, but just recommend that they tell us all the good opportunities that they have in the July meeting.

DR. MILLER: I will second the motion.

MR. CHAMBLISS: It has been moved and seconded.

Is there further discussion?

DR. MILLER: Could I ask the question from the staff's viewpoint, the fact that they said they were not going to come back in July does not mean they can't now change and come back in July.

MR. CHAMBLISS: They still can come in July, yes.

MR. TOOMEY: Question.

MR. CHAMBLISS: All those in favor?

(Chorus of ayes.)

MR. CHAMBLISS: Those opposed?

(No response.)

MR. CHAMBLISS: There is no opposition and the motion is passed.

DR. SLATER: The next round, all we are going to do is take a look at the 25 projects if they do it. We, in essence, covered the basic text of this Texas program.

MR. CHAMBLISS: Let us take a short recess.

(Recess)

MR. CHAMBLISS: Shall we resume?

Our next region for review is Ohio Valley.

The presenters for Ohio Valley will be Dr. Vaun and Mr. Thompson, backed up by Mrs. Parks from the staff.

There are, in this region, a couple of nuances, having to do with the two regions formerly in Ohio that are no longer in existence. There have been some special arrangements made permitting activities from Ohio to be incorporated into the Ohio Valley application.

I wonder, before the reviewers make their presentation, if you would just like to highlight those issues, so that it may be before the Committee as a whole.

MR. VAN WINKLE: What has happened is that the two Ohio's had been phased out, and, as this revival came around, we started getting inquiries from there, where can we apply? We don't have an organization, grantee.

Arrangements were made with the Ohio Valley Regional Medical Program to entertain such proposals, having them act as a grantee agency.

I want to call your attention to the fact that I believe Dr. Paul made assurances to them that in no way would affect their funding level, Ohio Valley's. I mean, it would not work to their detriment.

MR. THOMPSON: But, nothing in this particular request reflects that change.

MR. VAN WINKLE: I can show you where it is and that is what we want to point out. It would be on page 200, under "Discreet Activity Summary."

She indicates the feasibility studies from this study were conducted on four potential sites in the region. Dayton, Ohio, Southeast or Harlan, Kentucky, South-Central or Somerset, Kentucky, and Southwest, Georgetown, Ohio.

There are two Ohio's in there that are not fully developed yet.

Now, it may even extend on to include Lima, Ohio, and as far north as Toledo.

MR. THOMPSON: I guess I do not know about the previous geography about that craziness in Ohio, which, if I remember correctly, we tried to contract before.

So, in other words, Miami, where the Ohio University is, and the new medical school is going to be, was not originally in the Ohio Valley.

MR. VAN WINKLE: That is correct.

MRS. PARKS: Dayton.

MR. THOMPSON: Miami --

DR. VAUN: Where was Cincinnati before?

MR. VAN WINKLE: Ohio Valley.

MRS. PARKS: Actually, what happened, or is happening, as far as the Toledo-Lima areas are concerned, they, of course, have expressed interest in some kinds of activity with the Ohio

Valley Regional Medical Program. Part of it was through this particular activity that they are interested in, simply because it is a priority in that area.

There are three CHP "b" agencies within that area. One in Dayton, one in Lima and there is another one in Ohio. But there are three of them.

They have expressed an interest in coming together to form a consortium and once this is done they will apply to the Ohio Valley RMP for funds for the development of a sub-regional organization for health, manpower and training. The application has not been developed yet. There will be a meeting tomorrow in Dayton at the Health Planning Council office and it will include representatives of the three CHP "b" agencies within that area, representatives from the academic institutions, health service institutions, "a" agency, Dr. Milligan will be there, and program staff from Ohio Valley and I think several of the regional advisory council members from the Ohio area, Dayton, Ohio.

And the purpose of the meeting is to discuss this arrangement with the Ohio Valley and if they are interested in it, then they will make an application to the region for funding.

It will still be subject to the Ohio Valley Regional Advisory Council's approval.

They do not envision that it will be ready for the next meeting of the council, which is July. They figure October,

which is when the council meets again, will be too late.

MR. VAN WINKLE: You are talking about the third council.

MRS. PARKS: The Ohio Valley council, RAG, they call it.

So what they are aiming for is to, with the assistance of the staff from Ohio Valley, help in developing a project and have it ready by August, and it is a possibility that the RAG will empower the executive committee to act and either approve, or whatever.

But the RAG, back in 1972 and 1973, developed some specific guidelines for the development of these sohmets, and this is the reason for the meeting tomorrow.

They are going to inform this group of what these guidelines are, and if they can conform to the guidelines, then their application will be entertained.

MRS. WEIKOFF: Is this the 27(a) through (h) or just 27(d)?

MRS. PARKS: The funds budgeted in 27(d) will provide funding if the application is approved for the Dayton, Lima and Toledo area.

MR. THOMPSON: You said two Ohio programs went down the tube?

MRS. PARKS: I beg your pardon?

MR. THOMPSON: Did you say two Ohio programs went down

the tube?

MR. CHAMBLISS: Were phased.

MR. VAN WINKLE: Cleveland and Columbus.

MR. CHAMBLISS: Known as Ohio State.

MR. THOMPSON: What about Toledo?

MR. VAN WINKLE: Toledo was phased out earlier.

MR. THOMPSON: I will be damned.

MRS. PARKS: And it only covers certain parts.

MR. VAN WINKLE: This is the only way that we can accommodate any requests from the State of Ohio.

MR. CHAMBLISS: Now that you have been informed on future project activities in Ohio, may the presenters commence?

Thank you.

DR. VAUN:: I thought you were going to make our job easier by introducing the Ohio comments, but what you have done is make it more difficult.

I don't think it has changed one iota, my comments, and one iota on the budget, but it is an enlightening thing.

What it is going to do is compensate the leadership for the Ohio Valley program which, in my view, seems complicated now. That is, it would appear that the leadership of this RMP is somewhat of a coordinator of a troika, and I am not sure how this new partner is going to alter that situation. To wit, it would appear that the leader of this program has been an architect of sustaining an isosceles triangle and making sure

that all the angles remain the same, and now you introduce another angle and this is going to foul up the whole mess. This will come out in the proposals.

The reason I say your comments are not going to interest me is because the proposals are not going to be altered one iota by another group, and my criticism will, I think, remain valid. It would appear that RAG has sustained its effectiveness.

I am a little surprised, in looking it over. I shouldn't be surprised from the nature of the project, that there are six of the 40 identified as medical center officials. There are nine also that I would identify as medical -- there are probably several others who are quasi-medical center officials, so that the program is, although adequately represented, it is heavily oriented to the three medical centers.

It would appear that their CHP relationships have been okay.

Jean was good enough to fill me in on some staff changes and she may want to comment further, because the numbers on our yellow sheets were incorrect, and I was a little startled by thinking that they were expanding and they are not really expanding. Their full-time professional staff is going from nine to fourteen, and these are primarily vacancies and not new positions.

Their full-time others is going to 47, so it would be a total of 21. There are fourteen now. Most of them are unfilled vacancies and not creating new positions.

Jean, you also indicated to me that their deputy director position has been filled?

MRS. PARKS: Yes, I learned several days ago that a former member of the program core staff has been approached by the Executive Committee to assume duties, effective August 1, as deputy coordinator, Bill Fox.

DR. VAUN: I think that will help with the increased amount of money that they are asking for in the funding.

With regard to their proposals, my criticism is that the problems in Lexington, Louisville and Cincinnati, seem amazingly alike, both from the point of view of level of funding and type of problem. To wit: I really can't understand how they would have the guts to apply for three colcimetry centers in Louisville, Lexington and Cincinnati, almost to the identical dollar figure.

I mean, that is a slap in the face that I just don't understand how they could do that to us, but they did.

In any event,I just took the worst of the ones without going down to indicate that almost all of the other projects are a third for Louisville, a third for Lexington and a third for Cincinnati. Whether it is ambulatory care, it is a third, a third, a third; that is why, I think, the leaders are going

to be in a difficult position when they introduce the fourth.

I am not -- I should not be too critical because, apparently, this program has been able to move with this problem, and in other areas, this influence has paralized other areas.

I might point out that I arrived at my deduction in a rational way. I think the nature of this proposal reflects their leadership. They are heavily involved in ambulatory care, they are heavily involved in the ad hoc proposals and, Jean, unless you would want to add something more at this point about what I have said before I give a figure, I am ready to pass it on to my fellow reviewer.

MRS. PARKS: I agree with what you say about the medical centers being funded. They seem to come in three's. But, I don't feel that they have created quite the severe problem as you have discussed, and maybe this is my biased opinion.

As far as the activitfes are concerned that they have developed, I think most of them have been developed, really based on study after study after study within the region and they, the activities, were developed from these studies, based on the needs of particular areas, and they have sort of moved on the basis of that.

DR. VAUN: It is a simple, technical fact that one dolcimetry center could handle all three States put togehter

okay.

MRS. PARKS: Well, I wouldn't argue with that.

DR. VAUN: As I worked through the projects considering the nature of the overall project, I have arrived at a figure that I am happy with production, that comes pretty close to their targets, $514,900.

MR. CHAMBLISS: Is that your recommendation?

DR. VAUN: That is mine.

DR. MILLER: What is the amount?

DR. VAUN: $514,900.

DR. MILLER: For what?

DR. VAUN: Off of their request.

MRS. PARKS: That is a minus.

DR. VAUN: You didn't think it was an add-on?

MRS. PARKS: I thought it was a recommendation.

DR. VAUN: Their request was $282,536. My identified reduction was $514,900, making recommendation $2,507,636.

MR. CHAMBLISS: Mr. Thompson:

MR. THOMPSON: I agree 100% with my primary reviewer.

I will say that although there were many letters from CHP agencies here, it is obvious that they are playing games because one letter here did not receive a proposal in time to review it. They didn't endorse it. They said they wouldn't turn it down but they would not comment on it. So, it happened to be that dolcimetry bit, which is fairly wild.

There was also a problem here about one of their home car programs, that the primary purpose of which, if I am not mistaken, was to stimulate the coverage of home care by Blue Cross programs. This stimulator had been in the works for four years.

It seems to me about time for them to fish or cut bait on whether or not Blue Cross will pick up home care.

Now, there happens to be a national policy for Blue Cross to do that, as much as there can be a national policy for Blue Cross, but that looks like a little bit of a long time to prove out that something is valid before somebody else takes over.

They have requested continuation.

DR. VAUN: That was one of the largest, too. That fourth year project was a $200,000 request.

DR. SCHERLIS: I just wanted to ask some questions.

The home care, as I add it, it comes to well over, well, it is about $491,000, is the sume requested for home care, a great deal of which is developmental, at least $200,000.

I am wondering what plans they have once this amount of money is withdrawn as far as what will happen to the need that they have stimulated within the community? It seemed like a rather short time.

I have other questions. Perhaps I can get some feeling on that.

DR. VAUN: I think this is what John was trying to raise in his point.

Now, they have been four years in the process and they are asking $200,000 again. So, the likelihood is that much of this is going to remain under-funded at the end of this year.

DR. SCHERLIS: The other two items that trouble me, ambulatory care, again, a developmental component of $150,000, and developmental for one of their sohmets or for at least the five additional sohmets. Their suborganizational response for health, manpower care and training, I think they have the very interesting, very long and very varied list of proposals.

But my concern even more here than elsewhere is what happens when that year ends? They will have built up needs, people and no vestige of opportunities, I think, for a great many of these to be supported, particularly, home care.

We have all been involved in the home care projects for a limited period of time. When they die, they die. There is nothing to fix them up and they were going down the road with $500,000.

MR. THOMPSON: Except management of the projects that we picked up in the past.

DR. WHITE: I am still not sure about this fourth one. There is some money that would be earmarked for them.

MRS. PARKS: For what?

MR. CHAMBLISS: For Ohio.

MRS. PARKS: Toledo, Ohio. The funds requested in 27(d).

DR. WHITE: That is the developmental complex.

MRS. PARKS: Yes, it is to provide funds for the development of sohmets in certain defined georgraphic areas.

They included in here some potential sites, that they plan to start them. The Toledo-Lima-Dayton ones would also be included, but they do not have the application from that particular group of people, as yet.

DR. WHITE: This $150,000 is again an escrow account?

MR. CHAMBLISS: It is for future project activities.

DR. VAUN: But, it would appear on the basis of some commitments by -- that is not totally an escrow. They were led to believe that they would have some access to the Ohio Valley program.

I am asking it again. Suppose it is awarded at the level you recommended instead of what they asked? Isn't there option to say to these other people, sorry, we didn't get all we asked for, therefore, you are out of luck?

MR. CHAMBLISS: We would have to give them specific instructions on that and we would await your judgment on this point.

DR. MILLER: Mr. Chairman, there are three projects I am asking the reviewers, there are three projects that are listed

developmental awards.

Are these projects -- is this another way of having $500,000 of a developmental fund which they can use as they choose?

One of them is home care developmental awards, $200,000. One of them is sohmet, $150,000, and one is ambulatory care and developmental components, $150,000. $500,000 of developmental funds. Is this all open?

DR. VAUN: It is not open and that is how I arrived at some of my reduction.

DR. MILLER: You are saying, essentially, that those are things that we disapprove of in engaging in?

DR. VAUN: That $200,000 care thing, as John pointed out, this is the fourth year. Now, how developmental can you be?

MR. CHAMBLISS: Is their specific recommendation on that particular part of the application from the committee?

MR. THOMPSON: I don't think we can tell them that we were concerned about, but if they want to give that, that is their prerogative. We need instructions to the region.

I think we can say that we were concerned about the odd coincidence of equal requirements for the same kinds of desperate towns, and the second thing we ought to tell them, we just really don't know how developmental the fourth year agreement can be. But that is up to them.

MR. CHAMBLISS: Thank you. We will note your concerns and we will entertain a motion.

DR. VAUN: I move that the request of the Ohio Regional Program be reduced by $514,900, to a figure of $2,305,636, with instructions to the region that the specific project that involves development components -- is that 27(b), Jean?

MRS. PARKS: Yes. Is that the sohmet activity -- yes.

DR. VAUN: May not be less than $100,000, may not be less than $100,000.

MR. CHAMBLISS: Is there a second to the motion?

DR. MILLER: Second.

MR. CHAMBLISS: It is moved and seconded that the level be for the Ohio Valley, $2,305,636, with the additional provisions cited by Dr. Vaun, applying to the region.

DR. WHITE: This 27(b), I understand, has not been through a review process.

DR. VAUN: No, it has not because this region phasing out of one regional medical program has been given access to this regional medical program, and I guess they just didn't have time to do it.

MRS. PARKS: No, that is not -- the process of handling developments of activities has been approved by the regional advisory group. They do have some areas identified that they

intend to fund. The Toledo-Lima situation, now, that has not been approved by the RAG, simply because they do not have the application yet. But, the process of providing funds to certain areas, provided they meet the guidelines, has been approved.

DR. WHITE: My point is, therefore, we cannot say no less than $100,000, unless we appended that, and they approve it as being a project, they would otherwise undertake.

The regional advisory group has to have the prerogative of approving this.

MRS. PARKS: Yes.

DR. VAUN: That is why I indicated no less than $100,000.

DR. WHITE: If they say it is no good, we don't want to do it --

DR. VAUN: How are you going to protect this region which is out in the cold right now, having been told they haven't access to this program?

DR. VAUN: And they would not be penalized because they were doing this out of the goodness of their heart and they also handled two arthritis proposals, and they agreed to monitor, evaluate and carry on all grantee activities for those particular projects.

MR. CHAMBLISS: As add-on's.

DR. VAUN: There is a way to obviate the criticism.

That is to guarantee the $100,000.

I think if they do not award up to $100,000 to this project, their request will be further reduced by $100,000.

DR. WHITE: This $100,000 can be used for that or nothing.

MRS. PARKS: I am sorry, let me get this clear.

In other words, the money that you are approving for 27(b) can only be used for the Toledo-Lima projects, if it comes in and is approved?

DR. VAUN: Right.

MRS. PARKS: They cannot use it to start up activities in some other sites?

DR. VAUN: No.

MR. VAN WINKLE: Would you award them 2205, whatever it is, and in the other, make an additional award if it comes through?

DR. VAUN: If you tell me that is the best way to say it, that way, and I will say it that way -- tell me what the rules are, and I will subscribe.

Now, I think you know what I am trying to say.

DR. CARPENTER: I guess if I understood, he said let us award them $100,000 less in July than if they come in with this sohmet up north, and we will give them another.

DR. VAUN: Is that what you are saying?

MR. VAN WINKLE: Your concern seems to be over this

sohmet, $100,000, whatever it is.

Let us say, in the award, that the 22 is for Ohio Valley and the X amount is for the other.

MR. CHAMBLISS: Making a total of $2,305,000, just as you have proposed.

DR. VAUN: I will revise my motion to accommodate that statement.

DR. SLATER: I wonder if Dr. Vaun would revise his position since he is within $10,000 of the target figure, and in view of all the criticism, why are we giving them more than 100% of their target figure?

DR. VAUN: Because I think I have arrived at my figure in a far more rational way than they arrived at their's. I have no way of knowing how they arrived at their target figures.

DR. MILLER: Which is the correct target figure? We have two.

MR. CHAMBLISS: The one on the long sheet is the laid-up one and the more correct one.

DR. MILLER: 35291 -- which is 45,000?

MR. VAN WINKLE: I would like to point out that the target figure is for Ohio Valley.

DR. MILLER: Their developmental project includes what they are going to give to Ohio Valley. So it is all in there.

MR. VAN WINKLE: I am only saying --

MR. CHAMBLISS: Your point is well taken, but the motion as presented by Dr. Vaun includes not only Ohio Valley, but the additional $100,000 to take care of Project 27, is that correct?

MRS. PARKS: Yes.

MR. CHAMBLISS: Now, question from Dr. Scherlis.

DR. SCHERLIS: As I recall, we had a great deal of fun and games in all of our previous review committees designating the various quadrants, or portals, in which we place various regional medical programs.

Could you refresh my memory and tell me where Ohio Valley was?

MR. CHAMBLISS: If I recall correctly, Ohio Valley was in the upper quadant.

MR. VAN WINKLE: You know, this particular project you are speaking of is $150,000.

MR. CHAMBLISS: We understand that. It has been reduced to $100,000. That is the point that he is making.

MR. VAN WINKLE: I thought he said not less than that.

DR. VAUN: You are satisfying me if you leave it the way it is.

MRS. WEIKOFF: Not less than $100,000.

DR. VAUN: The award to this region. My recommendation is $2,305,000, with additional $100,000 for 27(d), if the RAG

of the Ohio Valley approves it.

MR. CHAMBLISS: I think that is of sufficient clarity, Doctor, to be understood.

If they don't request that amount, then the principle of reversion takes place.

DR. SCHERLIS: Call for the question.

MR. CHAMBLISS: All right, the question. Those in favor of the motion?

(Chorus of ayes.)

MR. CHAMBLISS: Those opposed?

(No response.)

MR. CHAMBLISS: The motion is carried.

Let us now turn our attention to the application from Oklahoma.

OKLAHOMA

MR. CHAMBLISS: Oklahoma will be reviewed by Dr. Scherlis and Mr. Toomey with Miss Resnick as staff representative.

DR. SCHERLIS: For those of you who are perhaps not familiar with Oklahoma, perhaps I can give a brief history.

Oklahoma had been very heavily oriented toward professional education, and for sometime the feeling was that this was not only its main thrust, but almost its only thrust. This posed some problem.

It has always been very much procedure-oriented and this is apparent when you meet with both of the regional medical program advisory groups and when you review the programs that they had over the years. They have had a change as far as leadership is concerned.

Their present director is Albert M. Donnell, and in his letter of April 30th, with his grant request, I think he indicates some points that I would like to refer to because it at least gives some orientation to the rest of their application.

As he points out, the budget request which he submits is based upon how the money can best be invested wisely and productively in achieving the maximum cost effectiveness for short-run and also aids in the long run.

I think, and it is an important statement, because,

as you review their request, a great deal is based on cost effectiveness.

When they put together their application, they did it in a way that I think will merit some discussion. They said their program development began with a consideration of the past and present DRMP mission, including guidelines and priorities with anticipation as to the most probable cause of action Congress would take in formulating remedial legislation. ORMP structure was then closely examined, including its RAG organiation, past and present program activities, the staff structure and personnel capacities, and the roles relationships and functions between the grantee institution, OUHSC and ORMP.

The program then evolved and was further structured to demonstrate the willingness and ability at the State level for health planning, development, implementation and regulation to co-exist and function effectively, although under different organizational entities.

They submit this as being their new game plan. What they have done is to put together a series of projects and plans which relate to, I think, a great deal of emphasis on provider base and also on consortiums of hospitals to reduce costs as far as the various services which they give.

There are a few points which I want to make in this regard. They state they developed a program, the Oklahoma

Medical Program did not -- I want to emphasize, did not announce an open invitation to bidders to regional support funds for development of fiscal year '75 program. Since the regional health development area program, which they referred to officially as RHDAP, and has been adopted as the base program for 1974.

The program content was related to the question where to expand, which development induced them to existing RHDAP staffs and what supports are utilized in making the cost and quality effective.

What they have moved into, as best I can determine it, a structure called Regional Health Development Area Program, and, therefore, have developed several such areas throughout the State, and have built their future programs on this, basing part of this on the fact that they are not quite sure which direction RHDAP or CHP will go, so they are looking to an overall area type of programorganization.

They say that the major program thrust will include their continuation of remote coronary systems.

This has been areas where they have been quite successful in attracting a well-trained cardiologist to assist neighboring hospitals. I might add that he is one of my fellows and that is a very effective program from what I have heard from him, as well as other people in the area.

They have emphasized kidney centers, as part of the

programs that they wish to continue. They have been involved through their regional health development groups, non-profit corporations known as Medical Profit Systems, Incorporated. These are ways of sharing joint purchasing of drugs, IV solutions, various other services.

This has proved to be, according to their cost effectiveness analysis, helpful as far as reducing hospital costs, and becomes apparent as you go through their program, that a great deal of their emphasis continues to be on hospitals or providers working together as far as more effective cost mechanism.

In reviewing some of the things that we would like to do and their staff, I think it is important to emphasize a few things.

One, their executive director, Dr. Donnell, has been their for a year and four months. They have associate director, director of telecommunications, program director, program assessment, manpower development, placement service, emphasis, again, on education and, I guess, that which speaks most to what you can do through provider orientation. They do have significant vacancies on their staff that I calculated out as being approximately $56,000 a year and some of these are at significant levels.

In terms of what they would like to do with their money, they have asked for several regional health development

programs, that, as I total it, come to something like $500,000 for the total number of five or six which they have requested and perhaps to give you a flavor of what these would like to do, I can read from one of them, and many of them are put together just exactly the same way.

This concerns one of their medical product service groups which is under regional health development program. This was created for the purpose of achieving the following long-range goals:

Promote area-wide participation of hospitals, other health care providers and consumers, in exemplary programs for effective cost containment.

Improve the availability, accessibility and quality of health services throughout the area through a more sophisticated health care system in concert with State and area-wide health planning efforts.

Attract and better utilize health manpower in rural communities.

Promote expansion of shared services voluntary hospital organization concept.

They are the general ones.

Cost containment services will be pursued through the following activities: group purchasing to initially include drugs, I-V's and selected hospital supplies; shared services to include microfilming and printing; shared personnel,

commencing with dietary and medical record consultants.

They put them into each one of these areas. A whole wide range of programs which, if effective, would obviously accomplish a great deal. They point to a complement to their pharmaceutical, drug costs, 50%, I-V equipment by 40%, and so on. In each one of these areas where they have planned or existing systems, they point out that they have been able to reduce costs, or will reduce costs.

They have stated specifically in their general description that they are provider-oriented and certainly this has been one of their main thrusts, has been in that area. Other projects include program staff which is $387,000, EMS training, $100,000 -- so they are asking for a total of approximately $1,380,000. This exceeds their estimated 140% target, $1,000,000, by a total of $350,000. They have, as I pointed out, successfully developed some remote coronary programs. Their emphasis is obviously now on their regional health development area programs, which, if these work, can be very effective.

Much of the effort appears to be in really reducing costs by mutual purchases, the hospitals, and the others, as I have indicated, appear to be essentially continuation of the projects.

I will withhold any motion until there is further discussion, and we have had staff comments on that.

MR. CHAMBLISS: All right, thank you.

Mr. Toomey?

MR. TOOMEY: I think it is interesting that the thrust of the Oklahoma program has moved from their early cooperative programs in the clinical field and evolved as cooperative efforts in the management and the hospital operation.

I suppose the three major -- three or four of the major efforts in the hospital field today have to do with shared services, mergers, contract management and this kind ofoperation. The people in the hospital business look -- they look at this kind of evolution as being something really tremendously desirable because it takes many of the problems and many of the isolation factors related to small hospitals operating as autonomous individual institutions that are essentially uneconomic, because with small hospitals having to purchase things that they purchase and hire the kinds of people that they hire, in a small hospital and expensive -- for example, a dietician or social worker in a small hospital may not have enough outlet for her capabilities or her capabilities in that one institution alone. Whereas, the sharing of people, the sharing of resources, whether they be financial resources or personnel resources or equipment resources, has to be, as far as I am concerned, it has to be the move of the future in order to create some kind of an institutional health care system.

Now, I really only differ with them in the use of some words. For instance, to call it a health delivery system, I think it is probably wrong. I do agree, certainly, that it is an institutional kind of melting of services and sharing of services.

I look upon it really as a thrust in two areas. One is economics and the other is the enhancement of the manpower or the professional personnel who are basically in short supply and certainly if they can be shared it is desirable.

So, I can't help but be very much in favor of this kind of move in terms of the services, it enhances the services rendered to the people; it enhances the problems, the cost of containments. It has a very strong economic thrust in terms of value to the community and value to the institutions and value to the patients who use these institutions.

I think that it is an extremely desirable kind of thing and I think that it is certainly interesting, that it springs from the initial sharing going on in the heart disease, cancer and stroke and they moved over into the institutional fields, and I suppose part of the reason, I don't know whether Donnell, however, you pronounce it, is a physician, if you call him a doctor --

MR. VAN WINKLE: He is a hospital administrator.

MR. TOOMEY: Well, I remember that he was Donnell,M.H.A.,

which is a Master's degree in hospital administration, so I think it is, perhaps, just as logical for this guy as a hospital administrator to move his RMP in that direction as it is for a physician RMP directed to move his RAG in the direction of clinical services.

In either way, I think there are values to be gotten and Oklahoma, as a rural State, as far as I am concerned, with this kind of thing, is a very large degree, I would say, at the present time, you could look upon them as almost a model. What could be done from the institutional point of view with other institutions.

So, the only other question that -- the only question, really, that I had was the -- it is a small staff, but if you put it on a percentagewise basis, it is about a 70% increase in the staff that they are asking.

This is one place, Mrs. Resnick, where I think we have to lean on you to find out if that increase in staff, with the fact that their programs are under way, and they are just expanding them, rather than building in a lot of new ones, whether that is justified.

MISS RESNICK: I think they need some strengthening of staff. But I felt at first it was a little too much at this time.

The regional health development programs are well along as far as the models are concerned, because Enid and

Bartlesville have been successful. Enid and Bartlesville were initiated just as a pilot last spring with '74 monies, and they do want to expand and probably will follow the Bartlesville approach. They are getting very good reactions from the communities.

You are right, they feel this is an excellent mechanism for the rural area outreach and that is what it will prove.

As for this new staff, I can't speak to it exactly. I haven't been in the area and talked to Mr. Donnell. I think he needs some strengthening, but I am not sure that he needs that many people. Seven new positions are proposed. Four professionals and three clerical,administrative and that sort of thing.

MR. THOMPSON: Have you had any more definite relationships with CHP? When you get these programs, then CHP usually starts screaming.

MISS RESNICK: There are four funded eastern area CHP "b" regions which were extremely laudatory of the program.

One of the projects, if you will notice, is to assist in western Oklahoma. Actually, it is two programs in western Oklahoma will eventually go on their own, but right now it is a very weak area and they have had a rocky history with the CHP agency and even the "a" agency.

Mr. Donnell,:I think,was with the "a" agency and he is

well aware and sensitive to this development in connection with the CHP "b."

He feels that it is helping to strengthen the relationship.

Now, if that answers the question --

DR. SCHERLIS: I have tried not to put too much a qualitative feeling when I presented it. I come away quite cool to this.

I think a good many of these projects should have been done by the Oklahoma Hospital Association without having any semblance of involvement whatsoever, of any consumer groups or other regional cooperative ventures.

I did not know that he was a hospital administrator. If I had, perhaps I would have so identified him in the presentation and it would have been covered fully by that.

I say it only because I don't think this reflects a regional cooperative venture. I think it reflects the swing away from what they used to have. When they formerly were heavily oriented towards education, who was it, Dr. Dale Dromes, and I was very concerned because it was totally professional education and we spoke then rather prosaically of this or that medical program, having turned the corner, and Oklahoma seemed at that time never to find the correct corner or a correct corner to turn.

Now, they have turned and are still heavily provider

oriented, but now it is a different group which is providing that, and that is the hospital-based need and they are spinning off cooperations which are looking at what I think are very important aspects of mutual purchase of equipment, sharing of facilities, and I see that the thrust that they point to under proposals, are one thing. When they get progress, they can point to the facts that they are now reducing the cost of I-V equipment and now have joint microfilming,and so on, but these are the progress notes.

Under their whole area health programs, much broader thrusts are envisioned. But, I think they are doing first things first. Everyone does his own thing, and I think he is doing his own thing very effectively.

I would like you to react to that.

MR. TOOMEY: I react two ways. One is, you could conceivably say either the medical societies or the various medical schools, and all of the States have been involved in the contribution or dissemination of medical information to the outlying rural areas before RMP came in with its medical thrust.

You say the hospital association should have done it. Well, the hospital association is a collection of individual institutions just as the -- just as the medical society is a collection of individual physicians, and I think that each one has its own thing to protect.

I think that they are trade associations, either way,

and to say that in the profession of institution management the hospital association should inflict its desires for great development of an integrated health delivery system utilizing all physicians is any different from saying that the hospital association should indicate all hospitals, so that you have hospital systems.

You can argue one way and I think it is just as inappropriate, really, for me to say about that, about the medical association, just as it is for you to say it about the hospital association.

I think it is a major breakthrough in institutional management, which is for the benefit of large numbers of individuals. Granted it really is to the benefit economically and in terms of quality of care. It provides these things that were not provided before.

It is in a different context of clinical -- but it does provide an excellent, an increase in enhancement of the caliber of care within those institutions, and I think that, I think you are going to be interested in what medicine does, what nursing and dieticians and x-ray technicians and what the other people do. Because each has a bearing.

So, I think that, we are both talking from different points of view, but from my point of view, this is great.

DR. SCHERLIS: I don't mean this to be a debate. It is obvious we didn't get together at lunch.

MR. CHAMBLISS: A brief comment by Miss Resnick.

MISS RESNICK: The origin of these area development corporations was a manpower development device to begin with. It is not emphasized quite as much in this presentation as it was the last time and that is still a component of their operation. It is not just sharing costs and containments. It is manpower seminars, workshops, development of -- they will have a conference that is being spread out throughout these hospitals, so it is a little more than meets the eye.

I don't think it is exclusively a hospital management.

MR. VAN WINKLE: You wouldn't believe the community involvement in this program. Never saw such enthusiasm.

MRS. WEIKOFF: This is just a piece of the whole thing.

MR. CHAMBLISS: I wonder if the representatives are ready to make a motion?

DR. SCHERLIS: Recognizing that hospitals are important, I would move that we fund them to the level of their target, which is $1,033,000. This reduces what they asked by $150,000, which I do without conscience,really.

MR. CHAMBLISS: If you will look at your spread sheets, you will see the more current target figure is $1,062,337. Would that be covered in your recommendation?

DR. SCHERLIS: I would move -- yes.

MR. CHAMBLISS: Is there a second?

MR. TOOMEY: I will second it, and then just as an aside, tell you that you gave $62,000 more than I was going to ask.

MR. CHAMBLISS: All right, it has been moved and seconded.

Is there further discussion?

Dr. White?

DR. WHITE: Is there some concern on the yellow page about the duplication? EMS activities?

DR. SCHERLIS: We have been assured this is not a factor.

MISS RESKICK: It is just a continuation of what they have been doing. Very little additional money, training, and, apparently, it is acceptable.

MR. CHAMBLISS: Call the question.

MRS. WEIKOFF: Question.

MR. CHAMBLISS: Those in favor of the motion?

(Chorus of ayes.)

MR. CHAMBLISS: Those opposed?

(No response.)

MR. CHAMBLISS: The ayes have it.

I would simply wish, if I may indulge in the prerogatives of the chair, make the observation that not only is the coordinator of Oklahoma an administrator, I understand that his RAG chairman is a hospital administrator, one of your

reviewers, Mr. Toomey, is a hospital administrator.

Your staff assistant is a hospital administrator and so is your chairman.

And, I would say it is about time that hospital administrators became more involved. We have sought to get their participation over the years, and it now comes at a rather late date.

DR. SCHERLIS: Nothing succeeds like success.

DR. CARPENTER: Could I ask one question?

Is Mr. Maysor involved in the regional program in Oklahoma? You didn't see the name in the application?

MR. TOOMEY: No, I didn't notice.

MR. CHAMBLISS: I would like to note one thing for the record if I may, that at this late date in our review process, that all of the reviewers are still in the room.

I would like the record to show that. And, it shows certainly the commitment that our viewers have had to this process.

We do, indeed, appreciate the support that you are giving us in this review, and I will say that I hate to spoil what I have said. Off the record.

(Discussion off the record.)

MR. CHAMBLISS: Now, we are back on the record.

Our last region -- our next region for review is South Carolina. After South Carolina, we will have only one

additional region to come before this panel --

DR. MILLER: You have two.

MR. CHAMBLISS: Thank you for correcting me, we have two after this.

SOUTH CAROLINA REGION

MR. CHAMBLISS: Let the record show that Mr. Toomey has left the room for this review.

The reviewers here are Mr. Thompson and Dr. Vaun, supported by Mrs. Kyttle, who represents the staff.

MR. THOMPSON: South Carolina contains many of the problems that we have been discussion here today, such as slush funds.

Previous approval of contracts have not been completed and so let me just start out with a positive point.

There is on page 88 of the application, a thing entitled a chronology to boggle the mind. That reviews the history of the poor South Carolina project from 1972 back up to 1974, and it is true, it was a chronology to boggle the mind.

The program wasin the first year, I think, its triennium review program when the axe fell. Its RAG has maintained itself, although I have many problems with the RAG.

I went through it and I find out that the RAG, there is a total of 58 people, 24 of whom are physicians, ten of whom are educators, four of whom are nurses, four of whom are hospital administrators, ten of whom are other professionals. One dentist and there are four civilians on their RAG.

Now, whom they represent. Eight represent the State educational system, seven the voluntary health agencies, three of them are private M.D.'s just floating in there, four of them

official health agencies, four of them public State agencies, two in health planning.

Down on the bottom, after you go through, seven from hospitals and medical centers and, finally, six public representatives which makes one kind of wonder what kind of direction this program has gone into.

The proposals, then, are very clear and logically presented. I will try to sum up what this is.

The objectives are in six Roman numberals.

The regionalization of service, health manpower development improvement, strengthening of quality assurance efforts, special categorical interests, primary health care and advanced resources planning.

These reflect both inputs from the national and some inputs from the local scene. Each operational project is hooked directly, or indirectly, to one of these Roman numerals of overall priority areas.

However, do not be misled by the logic of this presentation. Because when one looks at the budget proposal which, by the way, this is now funded at $1,250,000, their target is $2444. Their request for this is $3,000,000 even and they have put us on notice that they are going to come sliding in with another $500,000, which is a pretty big growth for a program that has been operating at a rate of $1250.

When one examines their request, one finds that

Roman numerals, six Roman numerals, and the staff accounts for 67% of the total requests.

Now, in their defense, they have indicated several future projects that are in the pipeline of each one of the Roman numerals, and they are not. They did not like Texas saying, "Give us some money and we will put some of these things into effect."

On the other hand, they have asked an inordinate amount of money for the support of these Roman numerals, which are not connected at this time to specific programs.

When one looks at the specific programs, even though they only require -- only consist of 33% of the total budget, they are consistent with the main goals and they are consistent with what little I know of health problems in South Carolina.

In other words, there is a nurse wifery project, for example. There is a great deal of attention to quality control.

As you probably know, prenatal quality is a real problem in South Carolina and the prenatal death rate is very high, and they have paid attention to it.

I have some problems that some of the other quality control or mecical evaluation systems. They are institutionally based. Those hospitals that have been doing their job should have paid attention to Quality Control long before this word

became stylish to PSRO or to any other kind of way. But, I can't argue with this specific project.

Now, as far as the CHP relationships, something very interesting has happened. Evidentally, the CHP agency and the RMP agency got together and said, "What are we going to do with this unknown legislation that might be coming sliding down the pike.

So, they decided to get together to talk about an advanced health resource planning group. They are supposed to have the "b" agency, the "a" agency and RMP and $164,000 was allocated to this advanced health resources group.

Evidentally, they were going along when one "b" agency, I think it was the "b" agency of Charleston, zipped in on this proposal. Since it seems peculiar that one agency would scream, and the other didn't scream, I tried to find out from the staff if there was a funded MO down there. That somehow that "b" agency was the fault of the DRMP, because Dr. Margolis signed that grant and although they were no longer with RMP, it might have helped.. We are very much in a problem then that they are requesting to approve what is roughly $1,092,000, in these six Roman numerals, which really represent a lot of specific projects that have not been advanced.

Now I understand they have told the staff that if we give them this money, they will not come back in the next round.

In other words, they would take the money that we would

give, for example, to quality assurance, and give it away to some of the projects that they have in the pipeline of quality assurance.

I am very reluctant to do this, although I can see the rationale of it, because I think we would, in essence, be giving them one hell of a big slush fund.

It isn't that I don't trust them, but we haven't had anybody else recently tried that big a structure. Let me close then.

It is a well-written project. Probably the best written project I have ever seen from South Carolina. The priorities are carefully spelled out. The projects do relate to priorities. They are making a real attempt to get together with CHP and solve this. The health authority problem.

But I can't see giving them all this money for projects that are still unapproved.

I will close.

MR. CHAMBLISS: Thank you, Mr. Thompson.

Dr. Vaun?:

DR. VAUN: I don't think there is much doubt that the leadership program has come through on this very well. I think John has identified the makeup of RAG. I am not sure that it has made any difference in the thrust of the program, at least as I surveyed the projects. They don't meet too often, but apparently, they seem to get the job done. The staff, in my

opinion, looks good, and I think it couches the realization with CHP, in general terms. It is difficult, at this point, to forecast whether the divergence are good, whether they are checks and balances or forceps that may prove to be counterproductive. That may say a lot of it may not say too much.

I must admit that I was more confortable with this proposal before Texas -- and I mean that very sincerely. I think I could have been very comfortable coming up with some kind of recommendation before I saw what we did specifically with regard to Texas, and that is even more so here because two-third of the request is in this never-never land of advanced health resources planning. $164,000. Primarily, health care to be defined in contracts, that is 194. The other was 164. Special categorical interest, $404,000, etcetera.

I think John has identified this. There is no need for me to belabor it at this point. I think perhaps Mrs. Kyttle could help us.

MR. CHAMBLISS: Miss Kyttle, would you proceed?

MISS KYTTLE: Going back to RAG, RAG has evolved and is still evolving into what it is now. It was a 72-member body with 83 physicians on it, not too long ago, and they listened to get that RAG in a better balance, and as memberships wrote it, the balance is coming, it is not there yet, but it is coming.

But, South Carolina is and has been for some time divided into ten very precise medical districts. They are planning districts. They are economic districts, and they are well-settled districts for many matters in the States.

When regional medical programs began, it had a very tough time getting off in South Carolina, until it assured each district that a physician from each district would sit on what they thought would then be the governing body, but which turned out to be the regional advisory group and they have not moved away from that promise.

So, whatever evolves from the RAG, you are going to have ten representatives, one each from its medical district.

They call them civilians down there, too.

MR. THOMPSON: I know, I took it right off your checklist.

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MISS KYTTLE: The actual submission, that is not quite right in that they have not promised us that they will not come in. But we put the regions on a bit of a spot.

Before they heard words from this review cycle, we asked them to look what the next cycle would like and South Carolina dodged and said, depending on what comes out of this cycle, we will do this or this or this.

We had their proposal and it sort of boggled our minds and we hit the middle, the $500,000 is a middle contingency and for the purposes of producing this right, but not correct list here, we hit $5,000 out of all of the contingencies that South Carolina proposed right back to us.

If they get full funding they do not plan to come in. If they don't get full funding, and it is this or this or this and that is the kind of contingency this July 1 is.

With respect to the kinds of institutions that they are dealing with, South Carolina had, about two years ago when its hospitals got into accreditation and certification trouble and that has fostered some of this activity in some of the categories that you mentioned. CHP, the comments on the yellow sheet do not relate only to CHP.

In South Carolina there are at least five forces that have been active in their own rights and very active in watching everyone else. It is Appalachia, well-funded and

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strongly provincial. CHP, both A and B, external and internal problems. RMP, the State Health Department in which the "A" is seeded and the Governor has created a Health Welfare and Environment Council which is beginning to move State money around from everyone into everyone else and into the Governor's Office.

And South Carolina is politically, healthwise, in quite a turmoil right now.

I don't know whether it is that they are farther along in some States and they are getting to the range like that other States will get to or whether it is the approach, I just don't know and that is why I say I don't know whether they will be good checks and balances or counter productive. There is a lame duck Governor.

This Council that he has created has made two attempts, neither of which was successful, to get legislative life. It is just a dotted line out of the Governor's office and everyone wonders when the Governor goes, will the Council go. It is a political arena right now healthwise in South Carolina, to have pulled as much constituency together as South Carolina did, is remarkable.

MR. VAN WINKLE: Doesn't Westmoreland sit on that Council?

MISS KYTTLE: No, not on the Council, he is running for Governor.

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MR. THOMPSON: My official recommendation was that $2.2 million which is just under $1 million more than they have now, but is some $800,000 less than they requested and most of that money, I would suggest could be turned into the second review when some of these programs in the general areas were more specific. I am not making this as a motion. I am just saying this is what I came out with.

I would not be adverse to recommending the $2.4 million, but I don't think that we can give them in all due respect, all this money, these slush funds that they are requesting.

MR. CHAMBLISS: All right.

MISS KYTTLE: I alerted you that the pages of the application do show the people with whom they will be doing business with, the sites with whom they will be doing business with and the money that will be involved.

Unlike Texas, these have been received, identified, negotiated, some of the budgets have already been negotiated down.

There have been preliminary studies by CHP. CHP promises and that is part of the hang up there, their staff has to get through things that require the time, some even said we won't even need 30 days -- some of the submitters are B's and they can get by late June their internal process finished on these specific applications. They could have

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put a 15 in for everyone of them. They could have put a 16 in for everyone of them but they are not through their final review process and South Carolina is very precise about their review process with respect to their regional advisory group.

They would not put the 15 in this application because it hadn't gone through the second round through RAG. It has been through the first.

MR. THOMPSON: My problem is if it ain't in the book, I can't grab it.

MR. CHAMBLISS: Are there further points of discussion?

Dr. Miller?

(8) DR. MILLER: Dr. McPhedran and I, after yesterday's discussion and much discussion about slush funds, discussed about whether we should put a motion in that would establish the principle of the review committee not to approve any slush fund components of applications and we discussed it a little bit and decided maybe it wasn't going to come up and maybe there wasn't much point in putting up a motion that wasn't going to come up again and I just commented to him, I guess it has been inappropriate. It would have been a good idea to have the motion put in, because it seems to keep coming back, doesn't it?

MR. THOMPSON: In their defense, everybody is

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laying $2 on the horse race and covering all --

MR. CHAMBLISS: Is there further discussion?

Dr. White?

DR. WHITE: Miss Kyttle, you are implying that if this money was restricted at this time, in these numerical categories, that they would by July have these things in form which we could see, is that correct?

MISS KYTTLE: Yes, they were trying to obviate the necessity to come into the July cycle and come in September.

DR. WHITE: They were trying to save us a trip?

MISS KYTTLE: They were trying to save themselves two months, too.

They have made inroads with MUSC on contracts, affiliation agreements are tough for a year. Not too many of us have sat around and said that.

That is one of the beauties of a contract. In addition to it, contracts as Dr. Miller said, give you opportunities to do things that when South Carolina discovers the control of the contract, they like it, they have used them sparingly through MUSC, because they had to educate their grantee. Having done that, they propose the contract method with these.

These are -- and in that, it is merely a physical mechanism and I think the group got hung up on the differences

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between agreements and a project and a contract and they are all the same thing. They wanted to let them as of July 1.

Also in their application they said they would hope for July 1 beginning dates on the use and they will be ready to go by then, they tell us, because they will have had the opportunity to capture several things. They will have their full staff complement to monitor them for that full year in South Carolina and they do that precisely too.

They will have the opportunity to come through the review group here with the staff at its highest complement here in DRMP because they see the erosion coming to staff that Dr. Pahl mentioned, later, and they see the body that is meeting here today that they are not so sure that there will be the continuity of it in July.

MR. THOMPSON: What is the incidence of hypertension in children, does anybody know what the incidence of hypertension is in children?

Dr. Scherlis, do you know?

DR. SCHERLIS: No, I would assume you would be dealing with blacks as opposed to whites. You would have a much higher incidence but I don't know what the incidence would be.

MR. THOMPSON: They have a specific program for hypertension in kids.

MR. CHAMBLISS: I can comment briefly on that.

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That is the incidence of hypertension in black children does not seem to increase until the stress mechanism gets to working and that is towards adolescence and above.

DR. McPHEDRAN: I think it is quite significant in black adolescent children. I don't know how high it is.

MISS KYTTLE: Part of the interest of that activity is to nab beginnings of renal disease. As using hypertension in children, female children considerably.

DR. WHITE: What is a special categorical interest? Have you an idea what they mean by that?

MR. THOMPSON: The priority areas.

DR. WHITE: No, special categorical interests for --

MR. THOMPSON: That is IV.

DR. WHITE: I know what it is called.

MISS KYTTLE: Because the others deal with heart, stroke --

MR. THOMPSON: Hypertension, is their big one because they have a high black population.

MR. CHAMBLISS: Yes, but they don't develop the mechanisms to take care of the hypertension once it is discovered.

DR. SCHERLIS: Just screening.

MR. CHAMBLISS: The mechanism is not there, I think in all candor, that should be said.

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MR. THOMPSON: Diabetes is another one that is specifically mentioned in this, emphysema, arthritis, heart disease, cancer, they cover the whole categorical thing that they had in hypertension, that in the pipeline there are some peculiar ones, esophogean cancer.

MR. CHAMBLISS: I would like to get a sense of the committee's feeling on this application and call for a motion if I may.

MR. THOMPSON: My second reviewer has a comment.

DR. VAUN: Jesse, in the Texas write up, how much did you see where these contracts were going to and where?

MRS. SALAZAR: None.

DR. VAUN: My mentioning Texas, I think was unfair.

Miss Kyttle, I think you did mention the who and where?

MISS KYTTLE: And the budget and that is important.

MR. CHAMBLISS: The basic thing, would this Committee in its judgment wish to approve these before these issues are in fact settled there?

MR. THOMPSON: That is why the recommendation --

MR. CHAMBLISS: Would you put that in the form of a motion?

Index "Recommendation"

MR. THOMPSON: $2.2 million.

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MR. CHAMBLISS: The recommendation for a level of funding for South Carolina is $2.2 million.

DR. SCHERLIS: I second that.

MR. CHAMBLISS: It has been seconded by Dr. Scherlis.

Is there discussion?

Dr. Vaun?

DR. VAUN: John, I don't understand your submission. This is the award for South Carolina, period.

MR. CHAMBLISS: They can still come in.

MR. THOMPSON: There is $500,000 coming in.

MISS KYTTLE: There will be more than the $500,000.

MR. CHAMBLISS: There will be funds available at that time.

MR. THOMPSON: The $2.2 million is arrived at by taking out some but not all of these non-program areas.

MR. CHAMBLISS: Would you like that instruction to go to the region -- all right, we have a motion, we have a second, we have discussion.

Shall I call the question?

Those in favor?

(Chorus of "ayes.")

MR. CHAMBLISS: Those opposed?

(No response.)

MR. CHAMBLISS: The ayes have it and the level is

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set at $2.2 million.

I would call upon the Committee again to ask how we should spend our time for the balance of the afternoon? I am given to understand that the other panel will complete its work today. They will met at 8:00 o'clock, they will be available for a joint meeting with this Committee at 9:00 o'clock and I would like to know if you would like a break for a moment or would you like to continue?

DR. McPHEDRAN: 9:00 a.m.?

DR. SCHERLIS: Do we have any reason to meet from 8:00 o'clock to 9:00 o'clock if we complete these two regions? What would we do if we meet at 8:00 o'clock?

MR. CHAMBLISS: We would have no basis unless the Committee wished to look over what it has done and we would have a listing of all the actions that we have taken and a showing of the current levels annualized, the target amount, the request and the actions coming out of this group.

We can look at our work product as a whole.

DR. MILLER: Let us finish up.

SOUTH DAKOTA

MR. CHAMBLISS: All right, I would then ask you to turn your attention to South Dakota.

The reviewer there is Mrs. Salazar, staff support by Miss Resnick.

Mrs. Salazar?

(9) MRS. SALAZAR: In the interest of moving along, I will try to shorten this. I promise not to do as much as I did on Texas.

MR. CHAMBLISS: A little louder, please.

MRS. SALAZAR: The application is requesting 6 continuing activities and the RAG has 11 of them, with 5 new ones.

Perhaps it would be better if I start in the back of the summary that I see as a summary of this application. That the RAG and the staff are obviously addressing the peculiar needs of this State, very large rural area with limited man and woman manpower and resources in various remote locations.

They propose a consortium of educational institutions and health institutions to very innovative and creative approach to South Dakota's health needs.

Regionalization of the core of the center concept is what they are proposing, is well supported and the region is making every effort to bring supported activities to the

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point of self-sufficiency.

As most of you remember, South Dakota RMP pulled away from Nebraska-South Dakota which was the original planning grant as far back as 1969. The first program for South Dakota as a separate entity was extended through August of 1972. It gained operational experience immediately and submitted its first triannium application effort last year but because of pending phase out, it was never reviewed; is that correct?

MR. CHAMBLISS: That is correct.

MRS. SALAZAR: It was extended again in March of 1973 through January of 1974 and approved through June of this year.

I am telling you this because South Dakota seems to have an awful lot of starting and stopping and yet there is a great deal of continuity through the whole application, which is amazing.

At the time of the staff implementation crisis this year, a couple months ago, the region was found to be viable and energetic and it was certified, I believe it is excellent in its review criteria and procedures. It naturally has a great emphasis on rural out reach with a focus on man and woman power development through the process of regionalization.

There is an integrated process with CHP planning

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which is very remarkable, in that the CHP board is the RAG, the one and the same body.

Manpower training, the distribution and utilization of manpower are primarily important to the region and these elements are found throughout all of the projects.

I find this proposal a very exciting and well organized Western Plains, no nonsense language. It sets forth what it wants to do very matter of factly into two general categories of projects.

One, those that are designed to achieve their objectives within the 1975 framework of funding and;

Two, those with interim RMP support, and I think that is very significant that they specifically say this interim report can be given impetus beyond '75 to attain their specific goals or to achieve permanent status either independently or under other funding sources.

The staff appears ready to move into new avenues of health resource planning. There is already good chemistry that exists between the other health agencies. Coordination of efforts and cooperation with other agencies is very apparent in the application.

A quick review of the projects did emphasize the South Dakota commitment to improving health services that are not now adequately covered. Yet at the same time the application is realistic, it is very local, it is very regional and

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in response to the geographic handicaps and that very rugged climate that exists out there.

The in tandem operation of the CHP agency is quite visible in a State of 600,000. Of course the social and political and business interrelationships is more apparent than in under-populated areas.

The regional medical program there is blessed with a capable and dedicated staff and it has very enthusiastic and energetic support and I believe ongoing continuing support through the University of South Dakota.

The application states that this will be augmented by two additional program staff persons who have planning and evaluation expertise. It was a little unclear to me why the application, in the application, why the Indian involvement in the corps staff, when so many of their programs are based, have Indian populations, very large Indian populations in the State and out-reach. There is no more active involvement of Indians on the staff. Especially in view of many significant Indian problems in South Dakota.

MISS RESNICK: Staffing with Indian personnel -- well, they are using their Indian outreach through their RAG. There are four members representing the Indian reservation population and they are taking the service out to the reservation in those corps components, working very closely with the Indian area office in Aberdeen. It is Vermilion and I think

dm 15

their resources would be extremely limited. That is where the program is based.

That is the only explanation I can give for it. I think they take it out to the reservations rather than try to bring an Indian professional in where they have so few.

MRS. SALAZAR: They have some very talented Indian people in that State and that is why I was wondering why they weren't involved more at the corps level.

MISS RESNICK: I think it comes through only at the RAG and they take it out to the reservation areas from what I can judge.

MRS. WYCKOFF: The staff out there, there is other area staff.

MISS RESNICK: There is eight components from the staff and three or four deal with Indian reservations, preceptorship, allied health, a summer training program and they are very close to the Indian program.

MRS. WYCKOFF: I think Mrs. Salazar's question is, who is getting the jobs?

MISS RESNICK: I know she asked if there is an Indian person, professionals on the staff in Vermilion. The answer is "No," but the only explanation I can give that there are few resources around Vermilion and they carry on their activities right on the spot in the Indian reservation areas.

MRS. SALAZAR: They are used, in my estimate, for

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instance, are using some Indians as consultants to come in when there are deliberations that involve projects and planning for Indians.

It is very important to have an Indian there to find out if he wants to be planned for.

MISS RESNICK: There are four Indians on the RAG and it is through them that they are having the direct contact, as I understand it, with the Indian reservation problems.

MRS. WYCKOFF: They do the planning.

MISS RESNICK: One or two have made certain proposals but they have come from the Indian reservation or hospital program.

I thought you meant staff. There was -- there is no Indian staff.

MRS. SALAZAR: Yes --

MISS RESNICK: They are very much involved. The Indian health facilities and programs are very much involved in the Chair's activities and they have asked for help from the Oahe and the Lewis and Clark, wherever they happen to be close.

MRS. SALAZAR: I don't mean to imply that the program leadership is not energetic and well motivated.

MISS RESNICK: I think they are actively engaged with them.

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MRS. SALAZAR: The RAG is also very strong and active and has organized into several, what is obviously very productive committees.

The Chairman, interestingly enough is an author, rancher, farmer. He is well informed of State problems and involved in many community and educational health efforts, which is probably one of the reasons in the health education community concept. He is an active facilitator and I gather gets great respect throughout the entire State.

At the same time he is very adequately successfully representing all of their interests, of the CHP, as well as the RMP.

MR. THOMPSON: Is he on the CHP board as well?

MRS. SALAZAR: Yes, it is the same board. Forty-one members.

MR. THOMPSON: Fifty-one percent on the board?

MRS. SALAZAR: I think it is interesting to note that the executive committee of the RAG met six times in the last 12 months with almost 100-percent participation in spite of that rugged winter out there, weather and the climate too.

They seem to be very proud of the fact that their members also serve without remuneration.

MISS RESNICK: They have project consultants who serve without reimbursement.

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Many of them in this particular program.

MRS. SALAZAR: Just to wind up, the highest priority rating of the RAG was assigned to the emergency medical services. That program they have is very small and they are only asking for the training efforts, about $50,000 for that.

I presume that this means that there will be another application in emergency medical services after they try this one out.

MISS RESNICK: They are planning to and they are also going to come in here again in July 1.

The thrust is manpower development again.

MRS. SALAZAR: That is the next one. The two health committee based centers.

I believe based on the past experience of South Dakota, that the goals and program are achievable and the current momentum of the program indicates that they have a fairly good chance, I believe, a fairly good chance of setting out what they set out to do. Laudable, I think the CHP joint efforts are commendable.

I think that their efforts toward trying to bring Indian populations more actively into the program also are very commendable efforts and I recommend -- may I make a recommendation, Mr. Chairman?

MR. CHAMBLISS: You may indeed, Mrs. Salazar.

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MRS. SALAZAR: That we approve this application as requested.

DR. SCHERLIS: That would exceed their target by $531,000 by $198,000.

MRS. SALAZAR: Yes.

DR. MILLER: Being a neighbor and having had much to do with the Texas, I thought it might be worthwhile to say a little what I know about the South Dakota program and its relationships.

As it started out with South Dakota and Nebraska together, incidentally, the reason Northland was mentioned was before I ever came on board our big medical centers in Minnesota figured that we would have the Dakotas in Montana and a good deal of the upper Midwest and so I have had a lot to do with them -- it is a different story.

But they have, they couldn't join with North Dakota because they never get along so they joined with Nebraska, but they couldn't get along with Nebraska either because Nebraska tried to dominate them. So they are impeding movements which could have gotten started in South Dakota. But then Dr. Hayes, who was the South Dakota associated coordinator of the South Dakota-Nebraska program moved, left the RMP to become Commissioner of Health in the State and although I don't know, I suppose he is -- is he?

MISS RESNICK: Yes, very actively involved.

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DR. MILLER: He is completely attuned to this whole movement. And Mr. Brecken is an outstanding leader, staff leader and so forth, so that actually this region would if it had gotten going sooner, would have had the potential to achieve much further than it has now and we wouldn't have this limited target estimate which is based on this very late start.

MR. CHAMBLISS: All right.

MISS RESNICK: The target estimate is $571,000. I am sorry the yellow sheet was not updated.

(10)

MR. CHAMBLISS: We have a recommended fund of $571,000. The requested level of $724,417.

I don't have a motion yet to that effect.

MRS. SALAZAR: I said it was requested.

MRS. WYCKOFF: $729,714?

MR. CHAMBLISS: Would you restate your motion since there is some question about which figure you had in mind?

The targeted figure?

MRS. SALAZAR: $729,714 as requested. That is my motion.

DR. VAUN: I will second it.

MR. CHAMBLISS: It has been moved and seconded that the level for South Dakota be set at the requested amount of $729,~~714~~ 417.

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Is there a discussion on the motion?

DR. SCHERLIS: Yes. At the risk of antagonizing people who like myself are hungry, there are two specific programs that I have question about.

One is the PSRO activity of $100,000.

I was wondering if that is what we really want to support?

The next question relates to the medical genetics program which is a total of $46,000.

As I read their program, which is a very ambitious one, in States many times that size, I was wondering whether that is one of the prime needs for the State of South Dakota.

MISS RESNICK: They reduce the number of possible trainees and this is tied to the medical school, a point which I think Mrs. Salazar failed to make. A four-year medical school recently approved by the State legislature and now going up for approval by the National Association.

We met this professor and doctor in genetics, she has had support from a number of sources including a little bit from RMP last year to get started on this genetics program. She is looking for other funds and at the moment nothing is coming through. They think the States will support it within a year.

It is for this reason that they would like very much to have this continued and not lose what she has already

dm 22

accomplished and she is getting a lot of support from the medical profession.

MR. CHAMBLISS: What is the purpose of the project per se?

MISS RESNICK: It is a primary care, really, activity with a referral, a resource for referral of patients to professionals and to specialists.

MR. CHAMBLISS: What are they looking for?

MISS RESNICK: They are starting with --

MR. CHAMBLISS: All the chromosomes where you screen for genetics are abnormal?

DR. SCHERLIS: I think it is one of the programs in looking at many States, I would put as not high on a priority listing particularly as one looks at the needs of South Dakota.

I am not addressing myself to the needs of Dr. Virginia Johnson who is in charge of genetics at that school. I am trying to look at it from the point of view of what are some higher priorities in any of the projects that they submitted.

This is one reason that I wouldn't be able to support the motion because I would not particularly attach significant priority to that. What was their rating of that?

MISS RESNICK: The RAG rated that among the top

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three. And it had a lot of visibility.

DR. SCHERLIS: I don't know what they are going to do with this when they get it.

MRS. WYCKOFF: We hire all their products from California. We will hire them all in California.

You needn't worry about whether they need them in South Dakota. We need them in California so there is a place for them.

MR. THOMPSON: I would remind you that California is putting in for $8,017,000 and let them have their own genetics.

MR. CHAMBLISS: There has always been some policy questions about RMP support in this whole area of genetics, including sickle cell and the like.

I probed a bit just to get a chance to say that. We have, as a matter of policy, suggested that projects dealing with genetics and sickle cell should go to the NIH for support.

We will probably, although the committee has acted on some other genetic applications, there have been one or two in some of the packages, we will probably look at those before they, before they are recommended for funds.

DR. SCHERLIS: Comment on the PSRO.

MISS RESNICK: It is identified as PSRO by our old options. It is actually a continuing education activity

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which they started last spring at a very low level and it is to develop guidelines, I guess, and examine criteria which will be essentially a base for the PSRO organization which the State eventually hopes to organize.

MR. CHAMBLISS: The other policy issue, that is there are funds from other sources other than RMP. That is for strict PSRO.

MISS RESNICK: It is not a --

DR. SCHERLIS: I will differ with you for one reason. As I read their description of that project, it goes along the lines of saying the Federal Government will be funding sometime in the near future.

We are going to be geared up to ask for the funds when they come out.

MR. CHAMBLISS: Yes, pure and simple.

DR. SCHERLIS: Up to the present time --

MISS RESNICK: It is going to be a medical research foundation eventually and I think this is to enable it to get off the ground.

But I don't get the impression -- we have to restudy it.

DR. SCHERLIS: A minimum of 25 percent of practicing MD's to sponsor for this program as it goes through.

MRS. SALAZAR: I get the feeling that since the grant of the project is directed by the medical association,

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it seems to me that it is kind of a selling job.

MR. THOMPSON: Let them sell themselves for PSRO.

MR. CHAMBLISS: We do have prohibitions against directly funding operational activities in a PSRO. I would hope the committee would take that into consideration.

DR. SCHERLIS: May I suggest $100,000 off the suggested level. That we don't have to specify that it be reduced as a matter of policy.

MRS. SALAZAR: I feel that there is a kind of schizophrenia here because we have done some similar PSRO activities in regions that we have kind of glossed over.

MR. THOMPSON: Not today.

DR. VAUN: Apart from the PSRO, I don't hear anything in there that tells me there is going to be an operational PSRO. This is developmental PSRO.

There has been a lot more than 40,000 that has slipped through on PSRO. As far as genetics, it would appear to me if there is no genetic facility within the State of South Dakota, then I don't think establishing one in a medical school, and the only medical school, is something that we ought to turn down. With an Indian population like that, there is probably some genetic counseling that should be going on and if there is no other genetic counseling in the State, and my guess is there is not, I would be awfully

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hesitant to turn this down.

Maybe some advice should go to the department heads that they should try to conceal this money in some other way in other departments other than to try to train 20 technologists.

I think the money is worthwhile.

DR. SCHERLIS: I am going to make a comment which may be pertinent or not pertinent. I really think we get the States that are asking for small sums of money, out tendency is to really use what is a double standard in evaluation and when a State like South Dakota or North Dakota or Oklahoma come in and requests are made, our tendency is to say they are only asking for small sums anyway. Let us ask for additional sums.

I would think that other criteria, that we would question individual projects that they are doing, working, if this is the best way for the State to go in its overall program and strongly urge that some individuals go there to the site visit to see what they are doing.

I have never approved the idea of funds from RMP going to medical schools unless there were strong needs expressed by other segments, for these services, and I think to use funds for that purpose, I would put it at a subsidiary level.

I think to take a program which is now at a level

dm 27

of, let's see, $428,000 and to talk in terms of their handling $300,000 more, is proportionately a large difference.

Now, I would like South Dakota to be able to utilize funds of a much larger nature. But I would have hoped more productively than this. Even if we reduce it by $100,000, they are still getting over $100,000 over the targeted figure.

I don't know if this is the wisest use that we can recommend for it.

MISS RESNICK: Their base is also a planning base. Unlike the other programs they were the only planning program, that is planning status; and they just became operational. It was a fact of life in the calendar.

So that base is a little bit unrealistic but they seem to indicate that they could use the additional amounts.

DR. SCHERLIS: I would rather they put it in to developmental or planning than into projects which they will have very little to do with.

DR. WHITE: I would like to voice a difference of opinion.

Since we are second-guessing what is best for South Dakota here in Washington, D.C. -- I am not through -- we have heard from both primary reviewer and someone who is

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familiar with the region, that this is a quality program and would have been farther along if not for certain political problems.

We have in the past two days reviewed other programs, granted them what they have requested. Sometimes it has been less or more than the target.

I can look at consultants for hospital-medical training units. Again, I don't know if that is appropriate, but I am not going to second-guess them. They know better than I do what serves their purpose.

DR. MILLER: Just one comment. The comment that has been made about action with regard to these, I drew the analogy to affirmative action and I think we do have a double standard. We want to support the have-not's. It is an affirmative action program, Reverse prejudice, if you like.

DR. VAUN: Question.

MR. CHAMBLISS: Those in favor of the motion of funding South Dakota at the requested level of $729,417, please let it be known by the usual sign of voting.

(Chorus of "ayes.")

MR. CHAMBLISS: Those opposed?

(No.)

MR. CHAMBLISS: There is one in opposition, Mr. Thompson.

It is approved.

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TENNESSEE MID-SOUTH

MR. CHAMBLISS: The last one for review is Tennessee Mid-South. The reviewers are Mrs. Wyckoff and Dr. Miller with Mrs. Kyttle supporting staff.

MRS. WYCKOFF: This is a request for $2,282,972 which is 72 percent of the target of which $370,000 is for program staff and $1,094,000 is for 18 continuing activities and $818,000 is for 21 new activities.

The present staff consists of 12 total, and proposed staff is increased to 18 with 2 added professional and 4 for support staff.

The former staff was approximately 36. Their present annualized rate is $1.5 million now.

The Tennessee Mid-South RMP coordinator is Dr. Richard Cannon, who has been on duty as such since last September, 100 percent of the time; but has been in the RMP since 1968.

He came on board when Dr. Teschan left.

Perhaps we ought to have a little background on what happened there. Dr. Teschan had a difference of opinion with the grantee and technically I guess was fired by the grantee. He is a Vanderbilt Medical School man who has tenure and is still there in Vanderbilt.

The new man, Dr. Richard Cannon, the coordinator, is also a Vanderbilt man with tenure. The big problem that

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arose was the communication of this RMP by Vanderbilt. It was very -- the board, the RAG was regarded by Vanderbilt as its creature and they weren't about to let go until there was some pretty strong urging from RMP that this had to be more of a tripartite-type program with the RAG independent of Vanderbilt and with the coordinator independent.

(11)

So there was a big paroxysm and I think the RMP went down there and gave the parties a Dutch uncle talk and the act, the results were described in the report when the recent -- this report says on September 9, 1973 in a magnificent maneuver of parliamentary procedure, the RAG dissolved itself, reorganized a new RAG and adopted new by-laws, all in the same meeting.

They formed a smaller RAG of 36 members with broader representation limited to one three-year term and elected an executive committee with broader representation. And the grantee responsibilities were closely defined.

This was the real problem with trying to get all of these people and organizations in the right place.

The new chairman is a University of Tennessee man, Dr. Cannon, and they have on it the president of the university at the South, he is the vice chairman, of the University of the South at Sewanee. I was not able to identify much more than three consumers or four consumers that really, if you can call them consumers on that board, all the rest

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providers, so in a sense it has not been a very great change in the character of the board.

Their past performance has been good in a sense, they have carried out their five priorities, access, regionalization of health services and the sharing of scarce resources; high quality of health care at reasonable cost; community-based health manpower consortium concept; and the promotion of more effective utilization of health care resources. These are the principal goals.

In the past two years they funded 68 separate activities totaling $2,246,165 as follows:

Primary health care and emergency medical service, 15 projects, $443,629, using for example nurse clinician and nurse practitioner primarily in rural and urban disadvantaged areas.

They have launched seven emergency medical service projects. $173,241 on that.

They spent $447,753 in new projects such as the nurse mid-wife teleconference program.

They have spent $414,392 on secondary care. Seventeen projects in hypertension, kidney disease with special emphasis on dialysis and organ-donor procurement.

They have had five projects of $560,264 in strengthening of quality assurance efforts.

They have done regionalization, five projects,

dm32

$206,886.

For example high risk new borns to the medical centers for comprehensive care.

They summarize all this by saying they have taken care of 634,681 people -- 634,681 people received emergency service or approved access to primary care and 626,178 people received secondary or tertiary care. And 758 newly trained health personnel.

They take all of the credit for the RMP, which I guess is legitimate in telling the story which they did.

The budget now in the application, 49 percent is budgeted for continuation activities and 37 percent for new projects and 14 percent for staff.

They give -- well, I don't know, it is getting kind of late, I don't know how much you want of this. There are eight new projects, six of these relate to rural application health districts.

One concerns a disadvantaged area. There are eight new projects in secondary care and regionalization. They focus on cancer, hypertension, renal dialysis, venereal disease, pneumoconiosis surveillance and rehabilitation. There is excellent distribution of projects throughout their region.

Now, we have of the seven continuing projects, two have received State-wide attention. These projects, one

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at the University of Tennessee Memorial Research Center and Hospital, Knoxville; the other at Children's Hospital, Vanderbilt Medical Center, Nashville, are concerned with a coordinated regional high-risk, new born service. The service provides transportation in specially equipped vehicles, of high-risk new born's to respective medical centers for intensive secondary care. These two projects, when combined with a similar project funded by Memphis RMP, provide the State with a network of high risk, new born secondary care.

There is other projects that they emphasize is very important in the monitoring of high risk obstetrical patients at Vanderbilt University Hospital which is being expanded from 5 to 10 hospitals in the region.

Then they have 5 projects concerning the development of health manpower.

One relates to the maintenance man in the small community hospital and provides in-service training in basic biomedical engineering and safety procedures.

Another under the direction of the Tennessee Hospital Association coordinates health manpower needs in the region with production by education and includes the State Commissioner of Higher Education's Office in the program's direction.

An innovative program submitted by Aquinas Junior

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College, Nashville, attacks the problem of hospital trained allied health personnel, for example radiology technologists, respiratory therapists, dental hygienists who desire to move up the career ladder by taking additional educational courses and receiving the associate degree.

This is a planned work-study program which can be extended over a period of several years.

I would try to condense this.

In July they are coming in for a total -- let me see, $658,127 in addition. There will be $189,746 in primary care, $130,774 in secondary care; $88,463 in manpower development and $249,144 in quality of care and cost containment.

So that will bring them over the 105 I think it is percent limit.

I have been through this enormous number of small projects and I must say, having made a site visit there, I really was very thrilled to see the development of some of these projects that started out as just a little urge on the part of a small group of little students or some little effort to get something going, especially out in the Appalachian Region where the needs are so great and the terrain is so difficult.

I think they have done a job in cooperation with the Appalachian Regional Commission and with that incredible

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health organization that they have up there, that is really remarkable and I do give them credit and I would like to give the students of Vanderbilt credit for keeping the pressure on and getting these things done, really remarkable things. The faculty has cooperated, sometimes reluctantly but has cooperated to make these things become a reality.

There were only two projects that I raised a question about. One was a project in kidney health education in which they wanted to make a film for home dialysis. They wanted $125,000 for this and it seemed to me that there are plenty of films on home dialysis that have been made. I know we have made some in California and I think there have been quite a few films that have been made on this and I wonder if this was a legitimate expenditure and there was $24,000 for a program on life adjustment to cancer which seemed to me that they could refer to the national cancer situation, which those two would make a total of $149,000.

Those are the ones that I thought perhaps ought to be either deducted or I would like to hear some more discussion on these before making a final recommendation.

MR. CHAMBLISS: All right.

Dr. Miller.

DR. MILLER: I have very little to add. I agree almost entirely with what she has said.

This is a very needy region, there have been

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problems. I think a lot of their projects look like passive funding enrichment for organizations to do things that are or should be doing anyway, but nevertheless the needs are great and I share her views.

DR. McPHEDRAN: Are the two projects that you question, do you think that they are RMP guidelines?

MRS. WYCKOFF: The kidney educational film, I think someone ought to take a look at that and see if it is legitimate type of film.

MR. THOMPSON: There is no reason, unless they want to put it to country music or something.

MRS. WYCKOFF: Life adjustment cancer, I just think that perhaps --

MR. VAN WINKLE: There are certainly grant management regulations that they have to comply with in making a film. If they meet them there is nothing to preclude them from making the film.

But they do have to meet certain regulations.

MR. CHAMBLISS: There is an OMB clearance that they have to --

MR. THOMPSON: Tell them to buy one or rent one.

MRS. WYCKOFF: Yes. I would like to recommend that their budget be set at $2,133,000, a cut of $150,000. $2,133,972, which is $150,000 below the amount that they requested and it is even below the 73 percent of their target.

dm37

DR. SCHERLIS: They will be coming back.

MISS KYTTLE: They requested $2,283,000.

MRS. WYCKOFF: This is $2 million --

MR. CHAMBLISS: There is a motion on the floor.

DR. MILLER: I will second it.

MR. CHAMBLISS: Is there a discussion?

Dr. White?

DR. WHITE: I have been laboring on the question of ignorance. Before Dr. Scherlis says I know it, I thought there was some formula in determining this target.

MR. THOMPSON: There is. It is 140 percent divided, assigned out by the average daily budget for the past 15 years.

DR. WHITE: Why would theirs be $3 million? That is 200 percent.

MR. THOMPSON: But they went back and picked up.

DR. SCHERLIS: Tell us about that bookkeeping, will you?

MRS. WYCKOFF: That is an odd thing. It is $3 million.

MISS KYTTLE: I don't understand their target level. I didn't set it or compute it.

MRS. WYCKOFF: I used what was on the yellow sheet.

MR. THOMPSON: They took the present mix of

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monies and got how much of the total part they are getting now and then assigned that as a percent.

MR. CHAMBLIS: There must be an error there. There must be an error there.

DR. MILLER: It must be $2,718,000.

MR. CHAMBLISS: This is a computer error as opposed to being a --

MRS. WYCKOFF: Human error.

MR. VAN WINKLE: If you look at --

DR. SCHERLIS: It should be about $2.5 million.

DR. MILLER: Yes.

MR. CHAMBLISS: Giving us 40 percent of what the annualized level should be.

MISS KYTTLE: I think the annualized level is wrong. When the 6.9 was distributed, Tennessee Mid South didn't come in for any of it because it did not meet the logical base on which the 6.9 formula was developed.

Well, when the money stayed out there in escrow for so long and was not permitted to be used for the reason it was prorated, the longer it stayed out there, the less rationale there was to the base and so it was redistributed and Tennessee Mid South came in for almost $200,000 in the last days of its grant year that I don't think is reflected in its current annualized level of funding.

MR. CHAMBLISS: I would suggest --

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DR. SCHERLIS: I always feel that you are so clear and that I should understand you, but somewhere along the line I know you are right, but --

MR. CHAMBLISS: Let me suggest to the committee if you have discomfort here, we can clear this issue up overnight and present this to you in the morning.

There is a motion on the floor that has been properly moved and seconded.

I am at a loss to -- in light of this, how we should dispose of it.

DR. VAUN: That figure is related to the request and not the target date. So why don't we go ahead and vote. Then if there is a gross error --

MR. CHAMBLISS: If the committee is comfortable with that, we will certainly respect your wishes then.

Shall I call for the question?

DR. SCHERLIS: Question.

MR. CHAMBLISS: Those in favor?

(Chorus of "ayes.")

MR. CHAMBLISS: Those opposed?

(No response.)

MR. CHAMBLISS: The level has been recommended for the Tennessee Mid-South Regional Program at $2,133,952.

DR. WRIGHT: I would like to pursue this a little further if I may, Mr. Chairman.

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It is important to me because when I was not able to make a judgment in any other way, I figured it was no worse or better than ten others that we looked at. Thinking that somehow or another there seems to be some disparities on whether our decision-making was based on error in the last two days.

MRS. WYCKOFF: It is a very disturbing thought.

DR. MILLER: Their targeted funds is more than they asked for. We never gave anybody more than they asked for.

DR. WHITE: Their target funds may have been in error.

MR. THOMPSON: Whenever we did that, the way --

MR. CHAMBLISS: Is there further concern on the part of the panel?

DR. MILLER: What time do we meet in the morning?

MR. CHAMBLISS: Let me close out by saying one or two things here.

First, you have handled your charge in a very commendable way.

I think the committee should know that Miss Kyttle who has transferred from RMP to the Health Services Administration Division of Review, will no longer be with RMP. As a matter of fact, she has already transferred and I would like to take note of the great work that she has done over the

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years as a member of the RMP staff.

DR. SCHERLIS: I would do nothing other than to second that.

MR. CHAMBLISS: I would like the committee also to note the fact that Mrs. Edith Leventhal, who has been over the years one of the strong workers behind the scenes, has given me support here today and yesterday and has provided RMP with a good amount of staff support over the years.

I would like you simply to note her participation.

I would like to say that I know I express on the part of Dr. Paul and the Health Resources Administration and the Bureau of Health Resources Development for the support of and participation of this panel, and I would say that you have been very patient in tackling this job.

Finally, I think you would like to know that the other panel is still in the process of completing its --

DR. PAHL: They just started their last one a minute ago. This panel won.

MR. CHAMBLISS: It has been agreed that we would meet at 9:30 in the morning in the joint session in this room.

DR. PAHL: The arthritis meeting is meeting at 8:00 o'clock.

DR. McPHEDRAN: How long do you expect that meeting is going to take?

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MR. CHAMBLISS: Would you have an estimate on that, Dr. Pahl?

DR. PAHL: I would guess it would perhaps only be for an hour and a half because the purpose of the meeting is more basically the two groups and chairmen to see that similar topics have been handled equitably and to try to group the applications into a master sort of three-leveled tier, just these seem to be above average and these are good solid ones and these are perhaps weaker, but nonetheless satisfactory, but not try to do anything within the groups but this will be of help as we go to Council after this lengthy period of absence and make sure that similar problems have been handled equitably between the two panels.

I would see perhaps mid morning, get together at 9:00 o'clock, it seems to me that you ought to accomplish that in that period.

The word that I received from the other panel would be 9:30 as opposed to 9:00 o'clock.

DR. PAHL: Why don't we try to head for a target period of around 11:00, if 9:30 is the time for the other group?

MR. CHAMBLISS: Do you feel that this panel should meet for any further review activity in the morning?

DR. PAHL: Have you clustered your own applications into three groups?

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MR. CHAMBLISS: No, we have not.

DR. PAHL: If not, I would suggest you meet at 9:00 o'clock, take the applications that you have and sort them and by the time this little chore is accomplished and you have some coffee, I think the other panel will have finished its deliberations which will expedite the whole process.

MR. CHAMBLISS: At 9:00 o'clock.

Thank you very much.

MR. THOMPSON: May I commend our Chairman for an excellent job.

(Applause.)

(Whereupon, at 5:25 o'clock, p.m., the meeting was recessed to reconvene at 9:00 o'clock, a.m., on Friday, May 24, 1974.)

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